MINUTE OF
ARGYLL & BUTE HEALTH & SOCIAL CARE PARTNERSHIP (HSCP)
INTEGRATION JOINT BOARD
WEDNESDAY 28 SEPTEMBER 2016
COUNCIL CHAMBERS, KILMORY

Present :

Councillor Kieron Green	Argyll & Bute Council (Chair)
Robin Creelman	NHS Highland Non-Executive Board Member (Vice Chair)
Christina West	Chief Officer, Argyll & Bute HSCP
David Alston	Chair, NHS Highland Board
Louise Long	Chief Social Work Officer
Denis McGlennon	Independent Sector Representative
Dr Peter Thorpe	Secondary Care Adviser, Argyll & Bute HSCP
Dawn McDonald	Co-Chair Joint Partnership Forum, - Argyll & Bute HSCP
Kevin McIntosh	Staff Representative (Council)
Betty Rhodick	Public Representative
Anne Gent (VC)	Director of Human Resources, NHS Highland
Elaine Wilkinson	NHS Highland Non-Executive Board Member
Liz Higgins	Lead Nurse, Argyll & Bute HSCP
Elaine Garman	Public Health Specialist, Argyll & Bute HSCP
Allen Stevenson	Head of Adult Services (East), Argyll & Bute HSCP
Caroline Whyte	Chief Financial Officer, Argyll & Bute HSCP
Glenn Heritage	Argyll & Bute Third Sector Interface
Dr Kate Pickering	General Practitioner, Argyll & Bute HSCP
Linda Currie	Lead AHP, Argyll & Bute HSCP
Maggie McCowan	Public Representative
Heather Grier	Unpaid Carer Representative
Councillor Anne Horn	Argyll & Bute Council
Councillor Elaine Robertson	Argyll & Bute Council
Councillor Mary-Jean Devon	Argyll & Bute Council

In Attendance :

Stephen Whiston	Head of Strategic Planning & Performance - Argyll & Bute HSCP
David Ritchie	Communications Manager, Argyll & Bute HSCP
Sheena Clark	PA to Chief Officer (Minutes)

Apologies :

Dr Michael Hall	Clinical Director, Argyll & Bute HSCP
Catriona Spink	Unpaid Carer Representative

ITEM	DETAIL	ACTION
1	**WELCOME**	
	The Chair welcomed everyone to the meeting and introductions were made.	
2	**APOLOGIES**	
	Apologies were noted.	
3	**DECLARATIONS OF INTEREST**	
	Mr McGlennon, Independent Sector Representative, declared an interest in the outcome of agenda item 5i, Implementation of the Living Wage.	
4	**MINUTE OF INTEGRATION JOINT BOARD 4-8-16 & ACTION LOG**	
	Councillor Robertson requested that her concerns be recorded regarding the non-Minuting of comments by the previous IJB Chair, prior to the commencement of the last business meeting, in relation to Elected Members' feedback on the decision making process and communication and engagement relating to the redesign of services. Page 7, item 11 – concern was regarding the ***number*** of locality plans. *Noting the above comments, the Minutes were agreed by the IJB as proposed by Mr Creelman and seconded by Mrs McCowan.* Action log update : Item 1 – proposal will be brought to a future IJB meeting Item 2 – updated Item 3 – agenda item Item 4 – ongoing Item 5 – update to November meeting Item 6 – completed Item 7 – ongoing Item 8 – completed Item 9 – added to IJB development plan	
5	**Business**	
	5i Living Wage The Chief Financial Officer reported that the HSCP has been working with the adult care providers who employ care workers to ensure they will be able to pay the Scottish Living Wage from 1 October 2016, along with meeting the various requirements of Fair Work Practices. Argyll & Bute Council Procurement & Commissioning and Strategic Finance teams have had positive negotiations with each provider to reach agreements in principal over uplift rates to achieve this.	

	There is uncertainty and concern expressed by providers over the funding available for 2017-18 and beyond to accommodate the full year cost of implementation and any associated future rate uplifts. The Chief Officer advised that COSLA are in negotiations with the Scottish Government regarding future funding. The IJB will be updated as part of the budget process as to the position with future years funding and cost pressures. The Public Health Specialist asked the IJB to acknowledge the positive health impact for care providers in receiving the living wage and the need to raise awareness of equality and diversity. Following the detailed financial assessment process with providers, the total estimated cost to fund the Living Wage is £1.410m, which exceeds the original high level estimate of £1.3m by £0.110m. It was therefore recommended that discussions should be initiated with the Council over the funding passed to the IJB in relation to the resulting gap between the original estimated cost and the updated financial impact. The IJB was also asked to approve the payment of the uplifts proposed following negotiations to ensure providers can be financially supported to deliver on the commitment from 1 October 2016, and to make a decision as to whether to support the providers who are unable to make a contribution. *The IJB :* • *Noted progress on the work required to deliver the Scottish Living Wage since the previous report on 22-6-16.* • *Approved the implementation of the rates assessed and agreed in principal with the local suppliers to deliver the Fair Work Practices and Scottish Living Wage requirements.* • *Agreed to initiate discussions with Argyll & Bute Council around the additional funding provided for the Living Wage and the budget shortfall of £0.1m required to fund implementation.* • *Noted the ongoing requirement to continue to monitor and report on the financial impact for the IJB of the decision to pay the Living Wage from 1 October 2016.*	**CWh** **CWh**
	5ii Clinical & Care Governance Report The Lead Nurse presented the report. <u>Violence & Aggression (Restraint) Training in Argyll & Bute Hospital</u> – the programme of training is now underway and on target to ensure all staff will be up to date with restraint training by 31 October 2016. The Lead Nurse provided assurance that there is a more robust system in place for forward planning for training and included	

	in the Clinical Governance Risk Register. <u>Complaints</u> – the response targets for both Health and Social Work complaints remain challenging. A Rapid Process Improvement Work (RPIW) event is scheduled for 31/10/16-4/11/16 and it is anticipated that this work will contribute to learning to improve performance. Work is continuing in developing reporting for HSCP Health & Social Work complaints. Information on the grading of Health complaints will be requested from the NHS Highland Feedback Team. <u>Prevention of Pressure Ulcers: Provision of Mattresses</u> – different models of practice are being tested to address the demands on the service due to a constant and increasing requirement for category A mattresses in the community across Argyll & Bute. Information on Argyll Bute's compliance with the Scottish Government's target on pressure ulcers will be included in the next report to the IJB. <u>Delayed Discharges</u> - the July 2016 census return to the Scottish Government reported 16 people delayed in hospital >72 hours, relating to completion of assessment work and availability of care at home places. A number of key activities are being progressed to ensure the HSCP moves forward to achieve the delayed discharge target. The next report to the IJB will show trend information. Councillor Devon highlighted the apparent 2-step discharge procedure for some Mull patients, i.e. Glasgow to Lorn & Islands Hospital to Mull. The Lead Nurse will look make enquiries about this practice. *The IJB noted the content of the report, the risks identified and the risk management plans.*	**LH** **LH**
	5iii Infection Prevention & Control (IPC) The Lead Nurse presented the report. <u>Infection Surveillance</u> - Staphylococcus aureus bacteraemia (SAB) & Clostridium difficile infection (CDI) One SAB was reported in Lorn & Islands Hospital in June. The infection was community acquired and was not considered to be preventable and there were no learning points identified. Since the last report 1 patient was admitted to Islay Hospital with CDI symptoms following antibiotic treatment in the community. The patient recovered well and there were no learning points identified.	

	In addition to SAB and CDI, a number of other infections are monitored by the Infection Control Team. During September a ward in Mid-Argyll Community Hospital was closed to new admissions due to four patients being affected by norovirus symptoms, three of who tested positive. Staff involved in helping to control this outbreak were praised, in particular the ward staff for their pro-active approach. IPC Staffing and Cleanliness, Hygiene & Infection (CHIC) Meetings - a trainee Infection Control Nurse has commenced in post and has been accepted for post-graduate study with University of Highlands & Islands. She is currently undertaking initial orientation throughout the HSCP and is being mentored by an experienced Infection Control Nurse. CHIC meetings will move to bi-monthly in line with other operational units in NHS Highland. Mr Creelman requested that this change is closely monitored to ensure no detriment to IPC in Argyll & Bute ICNet – software is now being used for all clinical record keeping by the Infection Control Team, greatly improving communication within the team. Automatic data upload from microbiology laboratories is still awaited and the NHS Highland Infection Control Manager is in communication with the NHS Greater Glasgow & Clyde team and updates regularly. Microbiology Advice – concerns remain regarding difficulties in untangling microbiology advice and infection control advice as the pathways for infection control advice sit within NHS Highland and the microbiology advice pathway is via Greater Glasgow & Clyde Health Board. Risk mitigation measures are in place and are recorded on the HSCP Risk Register. *The IJB noted the content of the report, the risks identified and the risk management plans.*	
	5iv) Staff Governance Report The Head of Strategic Planning & Performance advised that the paper sets out the initial framework for a quarterly report to the IJB on staff governance in the Health & Social Care Partnership. Elements detailed in the paper provided the IJB with information on the staff governance issues which the HSCP and the respective employer bodies are addressing. - 3.4.1 – NHS PIN policy on flexible working – Glenn Heritage reported on comments at the National Meeting of the Third	

	Sector regarding inclusion of volunteers in the policy. It was noted that the policy is out for consultation and concerns raised will be fed back to NHS Highland. - 3.4.2 – NHS Band 1 Review – generic job descriptions have been circulated to the NHS Highland Partnership forum for comment re. Bank staff. - 3.4.3 – Council Terms & Conditions Issues – Kevin McIntosh expressed concern at the lack of engagement with Union representatives and discussion with Council staff in the decision making process around redesign of services, particularly relating to Struan Lodge and Thomson Court. The Head of Adult Services (East) confirmed that formal consultation is due to commence in October and will follow the Council process for staff and Trade Union engagement. He provided assurance that a Trade Union representative will be invited to attend meetings with staff and a meeting scheduled for this week will be re-arranged. Councillor Horn recorded her concern that Trade Union attendance was not requested at the scheduled staff meeting and this was endorsed by the IJB Chair. Engagement and Consultation feedback and information will be given to a future meeting of the IJB. - 3.5.1 – Attendance Management (NHS) – the Head of Children & Families provided assurance to the IJB that managing sickness absence and supporting staff is a priority area for the HSCP Heads of Service. *The IJB noted the content of the quarterly report on the staff governance status in the HSCP.*	**AS**
	5v) **Finance** a) <u>Budget Monitoring</u> The report by the Chief Financial Officer set out the financial position for Integrated Services as at end August 2016. The projected year-end outturn position has reduced by £0.5m to an overspend of £1.0m, indicating that progress is being made to bring the position back into line with the available budget by the financial year-end. The focus should continue to be delivery of the savings from the Quality & Financial Plan to reduce expenditure on a recurring basis. The forecast overspend position has decreased from the June report to £0.5m as a result of progress with the recovery plan, but has been partly offset by additional demand pressures and a forecast shortfall in the delivery of savings previously approved from social care services.	

	The IJB requested that the report to the November meeting includes a more detailed analysis of the HSCP's performance against the red risk savings as an assessment of the deliverability of savings. *The IJB noted the report and agreed that the previously approved financial recovery plan requires to continue to be implemented to ensure the delivery of a balanced integrated budget for 2016-17 financial year.* b) Annual Accounts 2015/16 The unaudited annual accounts for 2015/16 were produced within the agreed timetable and the statutory timescales and were approved by the IJB on 22 June 2016 for submission to the external auditors. The audit process has now been completed and the external auditor, Audit Scotland, have issued an unqualified independent auditors report. The audited accounts now require to be approved by the IJB prior to 30 September 2016. The timescales for producing accounts for future years will be very challenging given the differing financial year-end timetables of the Health and Council partners and adequate planning will be required to ensure the accounts can be produced on time. A draft year-end plan will be presented to the Audit Committee in December 2016. *The IJB noted the completion of the external audit of the annual accounts for 2015-16 and the unqualified independent Auditor's report. Approved the audited annual accounts for 2015-16 to be signed for issue and noted the challenging timescale in future years in terms of producing accounts and the requirement to plan with the Health & Council partners to achieve this.* c) Annual Audit Report 2015/16 The IJB noted the report presented by Brian Gillespie of Audit Scotland, and the requirement for the Chief Financial Officer to submit a draft timetable for the production of accounts to the Audit Committee for approval in December 2016. The ongoing monthly position will be reported to the IJB by the Chief Financial Officer.	**CWh** **CWh**
	5vi) Performance Report The national Health and Wellbeing Outcomes provide a strategic framework for the planning and delivery of health and social care services. Currently there are 9 key national Health and Wellbeing Outcomes and 23 sub-indicators which form the basis of the reporting requirement for the HSCP. The IJB requested a detailed examination of progress against 2 of the indicators at each IJB	

	meeting and this report presents information on Outcomes 1 and 2. Outcome 1 – people are able to look after and improve their own health and wellbeing and live in good health for longer. Of the 14 indicators being measured against this outcome, 8 are on track and 6 are off track. Outcome 2 – people, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community. Of the 16 indicators being measured against this outcome, 12 are on track and 4 are off track. The circulated performance and exception report provided the details of the indicators and the work in hand to bring them back on track. It was highlighted that a national review of NHS targets and the Health and Wellbeing Integration Indicators is to be carried out, independently chaired by the former Scottish Government Chief Medical Officer. The review is expected to report its initial recommendations by Spring 2017. *The IJB noted the HSCP performance against the 9 national Health and Wellbeing Outcome Indicators and the progress in the HSCP performance against outcomes 1 and 2, together with the action identified to address deficiencies in performance as detailed in the exception report.*	
	5vii) Public Health Report - Alcohol Morbidity and Mortality Position Alcohol use continues to cause ill health and social problems in Argyll and Bute. The complex work to resolve and prevent the problems is undertaken by Argyll & Bute Alcohol & Drug Partnership of which the HSCP is a partner. Whilst waiting times for alcohol treatment have generally been met over recent years the target for Alcohol Brief Interventions (ABIs) has not. Work to increase responsibility for delivery of ABIs is suggested to improve this position. *The IJB noted the paper and will receive a presentation on the full range of Alcohol and Drug Partnership interventions in early 2017.*	
	5viii) Directions from IJB to NHS Highland Health Board & Argyll & Bute Council The Chief Officer presented the report which asked the IJB to : - Note the legislation that requires Argyll & Bute Council and	

	NHS Highland to delegate certain functions to the IJB. - Note that in terms of the legislation in order to secure the performance of the above functions the IJB must give a direction to either the Council/NHS to carry out those functions. - Agree to authorise the Chief Officer to direct the Council/NHS to perform/carry out the functions. - Agree that the functions directed to the Council/NHS will require to be performed in accordance with all legal and regulatory requirements - Note that in terms of the legislation the Directions must specify the payments to be made or the method for determining what the Board will pay. *The IJB approved the direction of functions to Argyll and Bute Council and NHS Highland in terms of the Public Bodies (Joint Working)(Scotland) Act 2014.*	
	5ix Chief Officer Report The Chief Officer summarised the report, advising on : The official opening of Lomond House in Helensburgh by the Scottish Government Minister for Mental Health. The facility provides the opportunity for Helensburgh & Lomond Carers SCIO, Children 1st and the Child & Adolescent Mental Health Service (CAMHS) to co-locate in Lomond House. The opening of the outdoor gym at Blarbuie Woodland, Lochgilphead, which is a valuable community resource to improve fitness and health. . The Advanced Nurse Diabetes based in Lorn & Islands Hospital shortlisted for a national Best Educator Award for her work in supporting local people across Argyll & Bute to self manage their diabetes. The positive Care Inspectorate report received by the Helensburgh Children's Unit following an unannounced inspection on 13 January 2016 and the publication of the report in August 2016. The outcome of the Volunteer Awards organised by Third Sector Interface and the efforts and personal commitment by all the nominees to support others.	

	Attendance by IJB Members and Senior Managers at the recent public meeting organised by the Community Council in Cowal to listen and discuss the community's concerns on the redesign of Struan Lodge and Thomson Court. An update on Mull Health and Social Care services and progress on developing a full island wide primary care team for the Mull & Iona communities. *The IJB noted the report.*	
	5x Pharmacy Report The pharmacy service plays a significant role in clinical and financial management within the HSCP and beyond. As the IJB defines and develops services, in line with the HSCP Strategic Plan, the safe, effective and efficient use of medicines will be essential to ensure patients live long healthy lives. A pharmacist professional advisor will assist the IJB planning for the most effective use of medicines and delivery of pharmaceutical care within an integrated health and social care service. *The IJB considered and agreed the addition of the HSCP Lead Pharmacist to their professional advisors.*	
6	**Concerns Regarding a Care Home in Argyll** The Integration Joint Board agreed to exclude the public for this item of business by virtue of paragraphs 6 & 8 of Part 1 of Schedule 7A of the Local Government (Scotland) Act 1973. The IJB gave consideration to a report providing them with the details regarding the short term sustainability of care provision by a provider in Argyll & Bute and the potential impact on local service delivery. The IJB : • *Supported further work to explore all options which would ensure ongoing care is provided in the Care home.* • *Supported local managers to work with the provider to develop a partnership agreement.*	
	Date of Next Meeting : Wednesday 30 November at 1.30pm Council Chambers, Kilmory, Lochgilphead	

ACTION LOG – INTEGRATION JOINT BOARD 28-09-16

	ACTION	LEAD	TIMESCALE	STATUS
1	IT support to be looked at regarding Webex use for IJB meetings.	C West		Ongoing
2	Equalities Outcome Framework to be included in Comms & Engagement Strategy	D Ritchie / J Jarvie		Ongoing
4	Progress service redesign proposals as detailed in the templates.	Heads of Service		Ongoing
5	Equality Impact Assessments as noted.	Heads of Service		Ongoing
6	Engagement & Consultation feedback to the IJB.	Allen Stevenson	November 16	
7	The IJB will be updated as part of the budget process as to the position with future years funding and cost pressures.	C Whyte		Ongoing
8	Discussions will be initiated with Argyll & Bute Council over the funding gap to the IJB.	C Whyte	November 16	
9	Budget monitoring report to November meeting to include detailed analysis of HSCP's performance against red risk savings.	C Whyte	November 16	
10	Information on grading of Health complaints to be requested from NHS Highland Feedback Team	S Clark	November 16	
11	Include mandatory and statutory training in future Clinical Care & Governance (CC&G) Report	E Higgins		Ongoing
12	Delayed Discharge trend information to be included in CC&G report to the IJB	E Higgins	November 16	
13	Enquire about discharge procedure for island patients from NHS GG&C	E Higgins	November 16	
14	HSCP Lead Pharmacist to be added to the list of IJB professional advisors	C West		Complete

Minutes of Special Meeting of the Argyll & Bute HSCP Integration Joint Board
Wednesday 2 November 2016 in the Council Chamber, Kilmory,Lochgilphead

Present: Councillor Kieron Green, Argyll and Bute Council (Chair)
Councillor Anne Horn, Argyll and Bute Council
Councillor Mary Jean Devon, Argyll and Bute Council (Via VC)
Councillor Elaine Robertson, Argyll and Bute Council (Via VC)
Robin Creelman, NHS Highland Board (Vice Chair)
Elaine Wilkinson, NHS Highland Board (Via VC)
David Alston, NHS Highland Board (Via VC)
Anne Gent, NHS Highland Board
Christina West, Chief Officer of the Integration Joint Board
Louise Long, Chief Social Worker of the Constituent Local Authority
Caroline White, Chief Financial Officer of the Integration Joint Board
Elizabeth Higgins, Lead Nurse
Dr Michael Hall, Clinical Director for Argyll and Bute
Dr Richard Wilson, Registered General Practitioner
Elaine Garmin, Public Health Specialist
Linda Currie, Lead Allied Health Professional (Via VC)
Kevin McIntosh, Staff Representative, Argyll and Bute Council
Dawn MacDonald, Staff Representative, NHS
Denis Mcglennon, Independent Sector Representative
Glenn Heritage, Third Sector Representative
Elizabeth Rhodick, Service User Representative, Public
Maggie McCowan, Service User Representative, Public
Heather Grier, Service User Representative, Carer
Catriona Spink, Service User Representative, Carer

In Attendance: Douglas Hendry, Standards Officer
Allen Stevenson, Head of Adult Care, East
Lorraine Paterson, Head of Adult Care, West
Caroline Champion, Planning and Public Involvement Manager
Stephen Whiston, Head of Strategic Planning and Performance
Hazel MacInnes, Committee Services, Argyll and Bute Council (Minutes)

1.	APOLOGIES
	There were no apologies for absence.
2.	DECLARATIONS OF INTEREST
	There were none intimated.

3.	REDESIGN OF SERVICES AT STRUAN LODGE AND THOMSON COURT
	On 22 June 2016 the Integration Joint Board agreed to bring forward the Service Redesigns in Struan Lodge and Thompson Court to meet Service objectives in its Strategic Plan and to contribute to the additional cost saving that financial due diligence had identified. Standing Order 16.1 states that no motion which seeks to alter or revoke a decision or have that effect will be considered within a period of six months of the original decision. In this respect consideration was given to suspending standing orders and to a report which sought the agreement of the Integration Joint Board to pause the implementation process relating to the redesign of services at Struan Lodge, Dunoon and Thomson Court, Rothesay; to undertake formal engagement and involvement with communities. Following representation from the public and politicians in relation to the absence of community engagement on the redesign proposals for Struan Lodge and Thomson Court, alongside discussions with the Scottish Government Health Department and Argyll and Bute Council; additional support had been offered to assist with the financial implications of a delay in delivering the redesign and to conduct and involvement and engagement exercise on the proposal as well as an opportunity to consider alternative suggestions within the strategic context. As part of this request the Integration Joint Board were asked to consider the following - • Impact on residents of this delay in implementation • Impact on staff of this delay in implementation • "Precedent set", re slowing transformational changes and redesign programme across Argyll and Bute , thereby not achieving strategic plan objectives and performance targets • Achievement of Quality and Financial plan 2016/17 and implications for 2017/18 & 2018/19 • Reputational impact on the IJB • Service Risk • Assess the support offered for the additional engagement The Board was also asked to consider what other savings could be made to meet the funding gap identified; and should there remain a shortfall, to consider approaching Argyll and Bute Council to request additional financial support to cover the implementation of the pause to the proposals at Struan Lodge and Thomson Court. **Decision** The Integration Joint Board agreed to suspend Standing Order 16.1 and to agree –

	• To a pause in relation to the implementation process related to Struan Lodge and Thomson Court for a period of 6 months. • To a formal engagement and involvement process to be designed and implemented in December 2016 as detailed. • That without delay we write to Argyll and Bute Council requesting £185,000 in the knowledge that Argyll and Bute Council are aware of our circumstances and that this resource is specifically to facilitate a pause in implementation. The Integration Joint Board will go on to look at savings and if we manage to achieve financial balance at year end the money will be returned to Argyll and Bute Council. • To consider the outcomes from the exercise to inform its decision on the redesign and transformation of services in Cowal and Bute as part of its Quality and Finance plan for 2017/18 and 2018/19.

Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Agenda item : 5.1

Date of Meeting : **30 November 2016**

Title of Report : **NHS Highland Director of Public Health Annual Report 2016**
- **Loneliness as a Public Health Issue**

Prepared by : **Alison McGrory, Health Improvement Principal**

Presented by : **Elaine Garman, Public Health Specialist**

The Integration Joint Board is asked to :

- **Recognise the impact of loneliness and isolation on the health of the people living in Argyll and Bute.**
- **Support the recommendations laid out in the report to reduce the impact of loneliness in older people.**
- **Ensure area locality plans address loneliness.**

1. EXECUTIVE SUMMARY

All Directors of Public Health in Scotland publish an annual report. Hugo van Woerden's report for NHS Highland for 2016 concerns loneliness and health in older age. Loneliness is a significant public health issue and is associated with:

- Increased mortality to the same extent as smoking 15 cigarettes per day.
- Increased incidence of long term conditions such as dementia, heart disease, high blood pressure and depression.

Loneliness can occur during life transitions such as moving home or jobs, bereavement and retirement. The detrimental effects of loneliness on wellbeing and quality of life are apparent across the whole population but the health impacts particularly manifest in old age. Loneliness is defined as:

"...a negative emotion associated with a perceived gap between the quality and quantity of relationships that we have and those we want." Perlman & Peplau 1981

There is evidence that the harmful effects of loneliness can be mitigated and the report sets out a wide range of evidence informed recommendations to be taken forward by all Community Planning Partners in Argyll and Bute. The Health and Social Care Partnership is a key stakeholder in this agenda and will benefit most from a preventative approach to this problem.

2. INTRODUCTION

The Public Health Annual Report – Loneliness and Health was published in November 2016. It is a comprehensive overview of loneliness and contains chapters on the case for action, the political and social context in Scotland and recommendations for the future. It also includes local research on the incidence of loneliness in people aged 65 plus and qualitative feedback from people in Cowal about how relationships affect their health.

3. DETAIL OF REPORT

3.1 Incidence of loneliness across NHS Highland area

Age UK suggests levels of loneliness remained stable over the last six decades with around 10 percent of people aged over 65 years experiencing chronic loneliness at any given time. However, self reported loneliness in those aged 80 years and over increases to approximately 50%. In the general population 5% of people report often feeling lonely and 31% report feeling lonely sometimes. This number is likely to increase given the trend for increasing family dispersal, increasing number of older people, and the older people getting older. People are living longer and within NHS Highland we already have a higher proportion of older people than the rest of Scotland. In Highland, the population of people over 80 is predicted to double and for those over 90, to almost treble by 2035.

The results of the local research undertaken in NHS Highland showed that 8% of respondents reported experiencing significant levels of loneliness (51% response rate to a random sample of 3,000 people). This survey used a standardised tool for measuring loneliness called the De Jong Gierveld Loneliness Scale. This includes 6 questions to measure 2 aspects of loneliness:

- Social loneliness is the feeling of missing a wider social network (for example, feeling we lack friends and family);
- Emotional loneliness is a feeling of missing an intimate relationship (for example, feeling we lack a personal relationship like that of a partner).

The survey found significantly higher levels of loneliness in the following groups:

- Those living alone;
- Those with more than one long-term condition;
- Those with a disability, notably a visual impairment or physical disability;
- Those who provide unpaid care specifically those providing 20+ hours per week;
- Those with a weak sense of coherence.

3.2 Recommendations to reduce impact of loneliness

Loneliness is a prime example where there is potential to invest a relatively small resource upstream in order to achieve significant cost savings further downstream. However, system wide challenges are apparent when balancing public sector spending on service delivery to solve problems that already exist whilst having capacity to make preventative investments. Christie recognised this in 2011 when his Commission on the Future Delivery of Public Services stated:

"Public services find great difficulty in prioritising preventative approaches to reduce long-term future demand. Services often tackle symptoms not causes, leading to 'failure demand' and worsening inequalities." and:

"It is estimated that as much as 40% of all spending on public services is accounted for by interventions that could have been avoided by prioritising a preventative approach."

The report sets out a clear evidence base for how to reduce the impact of loneliness in chapter 5. This includes local examples of good practice and nationally informed recommendations including:

- Information and signposting services
- Support for individuals
- Group interventions – social support
- Health improvement interventions
- Wider community engagement

Final recommendations in the report include:

- The importance of mitigating the effects of loneliness should be recognised by all health and social care partners and wider communities. In order to achieve this:
    - The Public Health Department will continue to raise awareness of the risks of loneliness and isolation.
    - There will be comprehensive promotion and marketing to raise awareness and showcase examples of what is working in local communities to reduce social isolation and loneliness.
    - There should be understanding of the community nature of the problem of loneliness and the need for a partnership approach to finding solutions. This is an ideal subject for Community Planning Partnerships.
- The funding and support of preventative activity should be reviewed and prioritised. The financial savings of prevention should be better evaluated in order to quantify the benefits. The Public Health Department can help with this.
- Ensure the benefits of reducing loneliness and isolation are apparent in planning processes, for example Locality Planning for health and social care and Community Planning. There needs to be a balance between high level commitments in area wide plans being supported by tangible actions in local area plans. Local planning would benefit from being more joined up; at the moment health and social care planning and community planning are parallel processes.
- The promotion of a preventative approach to loneliness should focus on building capacity in the Third Sector so they can further invest in community based support. Careful consideration of funding models is required here due to the fragility of long term funding for these services.
- Innovative funding solutions should be explored in order to ensure preventative activity can be sustained. This might include participatory budgeting or public social partnerships.
- Current difficulties of short term funding arrangements for third sector preventative services should be acknowledged. The Public Health workforce should advocate for sustainable funding models to the Scottish Government.
- Ensure the principles of co-production are fully embedded in service design and delivery i.e. people informing and shaping the services they want. Support for co-production should be intensified and statutory sector bodies should critically appraise their ways of working and remove potential barriers to co-production.
- Embed the principles of social prescribing in health and social care delivery to ensure people with underlying social problems at the root of their health problems get referred or signposted into appropriate sources of support by their health professional or care giver.
- Ensure people experiencing or at risk of loneliness are able to access appropriate services. There may be practical barriers present so consider community transport for those who may have difficulty using their own or public transport.

- The Public Health workforce has a recognised advocacy role for improving population health, for example, in support for smoking and alcohol legislation. They should make representation to the Scottish Government about the levity of social isolation and loneliness on health outcomes and the need to have high level leadership for action. This lobbying should be cognisant of the fact that reducing loneliness transcends a wide range of policy and strategy rather than simply being a health and social care issue.
- Local activity on Reshaping Care for Older People should be reviewed and refreshed by health and social care partners.

4. CONTRIBUTION TO STRATEGIC PRIORITIES

Addressing loneliness and isolation contributes to the delivery of all the HSCP strategic priorities:

- **Promote healthy lifestyle choices and self-management of long term conditions**
- **Reduce the number of avoidable emergency admissions to hospital and minimise the time that people are delayed in hospital**
- **Support people to live fulfilling lives in their own homes, for as long as possible**
- **Support unpaid carers, to reduce the impact of their caring role on their own health and wellbeing**
- Institute a continuous quality improvement management process across the functions delegated to the Partnership
- Support staff to continuously improve the information, support and care that they deliver
- Efficiently and effectively manage all resources to deliver Best Value

5. GOVERNANCE IMPLICATIONS

5.1 Financial Impact

The difficulty of finding money for preventative approaches is fully explored in the full report and recommendations are presented to utilise opportunities for co-production of local solutions and building capacity in local communities for this. Nonetheless, short term funding streams like the Integrated Care Fund are currently offering opportunities in this area.

5.2 Staff Governance

Staff would benefits from an overarching publicity strategy to identify why this is an important action for the HSCP.

5.3 Clinical Governance

Reducing loneliness is a wider community target, of which the HSCP is only one partner. Other partners include third sector, independent sector and community representatives.

6. EQUALITY & DIVERSITY IMPLICATIONS

Tackling loneliness and isolation is a population wide agenda but the report identifies that some groups of the population are more at risk, for example, those living with more than one health condition or those with a sensory impairment. Action plans should be inequalities sensitive and ensure those most at risk can benefit most from interventions.

7. RISK ASSESSMENT

None carried out.

8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

The annual report is the next step in a long standing campaign to raise awareness of the adverse effects of loneliness. There has been significant engagement with the public and other partners for a number of years in the following activity:

- Focus groups to explore people's awareness of the link between relationships and their health
- Learning events
- Facebook posts and wider awareness raising
- Promotion of *Reach Out – make a difference to someone who's lonely* pledge

9. CONCLUSIONS

The Annual Report – Loneliness and Health will be widely disseminated across NHS Highland. The support of the IJB and HSCP is sought to ensure that it can achieve the aim of reducing the adverse effects on loneliness on the health of our population.

Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Agenda item : 5.2

Date of Meeting: **30 November 2016**

Title of Report: **Clinical and Care Governance**

Prepared by: **Fiona Campbell, Clinical Governance Manager on behalf of Liz Higgins, Lead Nurse**

Presented by : **Liz Higgins, Lead Nurse**

The Integration Joint Board is asked to :

Note content of report, the risks identified and the risk management plans

1. EXECUTIVE SUMMARY

Report detailing:

1. Violence and Aggression (Restraint) Training in Argyll and Bute Hospital (update)
2. HSCP Complaints
3. Lorn and Islands Hospital (LIH) - Laboratory Services
4. Lorn and Islands Hospital - Hospital Standardised Mortality Ratio (HSMR)
5. Craigard Care Home, Bute / Care Home Governance

2. INTRODUCTION

Clinical and care governance is the system by which Health Boards and Local Authorities are accountable for ensuring the safety and quality of health and social care services, and for creating appropriate conditions within which the highest standards of service can be promoted and sustained.

Clinical and care governance is the process by which accountability for the quality of health and social care is monitored and assured. It should create a culture where delivery of the highest quality of care and support is understood to be the responsibility of everyone working in the organisation – built upon partnership and collaboration within teams and between health and social care professionals and managers.

It is the way by which structures and processes assure Integration Joint Boards, Health Boards and Local Authorities that this is happening

This report outlines the current Clinical & Care Governance issues that require to be noted by the IJB and outlines action taken to address safety and risk.

3. DETAIL OF REPORT

3.1 Violence and Aggression (V&A) Restraint Training Argyll and Bute Hospital (Update from previous report)

All staff working in acute mental health are up to date with restraint training. A programme of five, three day restraint training courses were delivered August – October 2016.

A total 43 staff have been trained, including 10 bank staff.

Systems have been developed to ensure that in future staff training will not lapse and plans are in place to book staff on to refresher training.

3.2 Argyll and Bute Complaints

3.2.1 Health Complaints

As requested at the last meeting, a copy of the Risk Assessment Tool for NHS Highland Complaints is attached to this report (Appendix 1).

Table 1: Health Complaints July – September 2016

HSCP Health Complaints	Expected Number	AMBER	RED	JULY	AUG	SEPT
No complaints received	7	8	9 and over	7	6	11
No investigated				7	6	10
Overall - achievement against 20 days	100%	90 - 99 %	89 % and under	14%	0%	0%
Number of high risk complaints received	1	2	3 and over	1	1	0

Figure 1: Number of Health Complaints Received Setember 2015 – September 2016

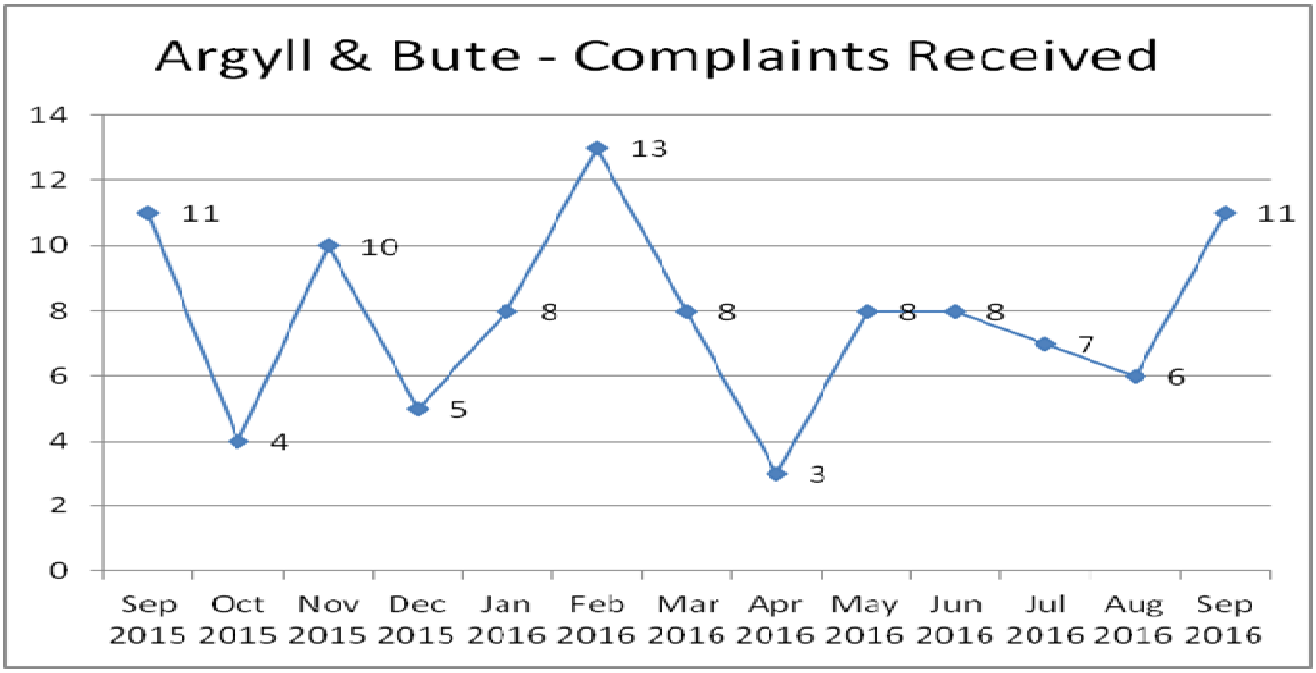


Figure 2: Grade of Health Complaints September 2015- September 2016

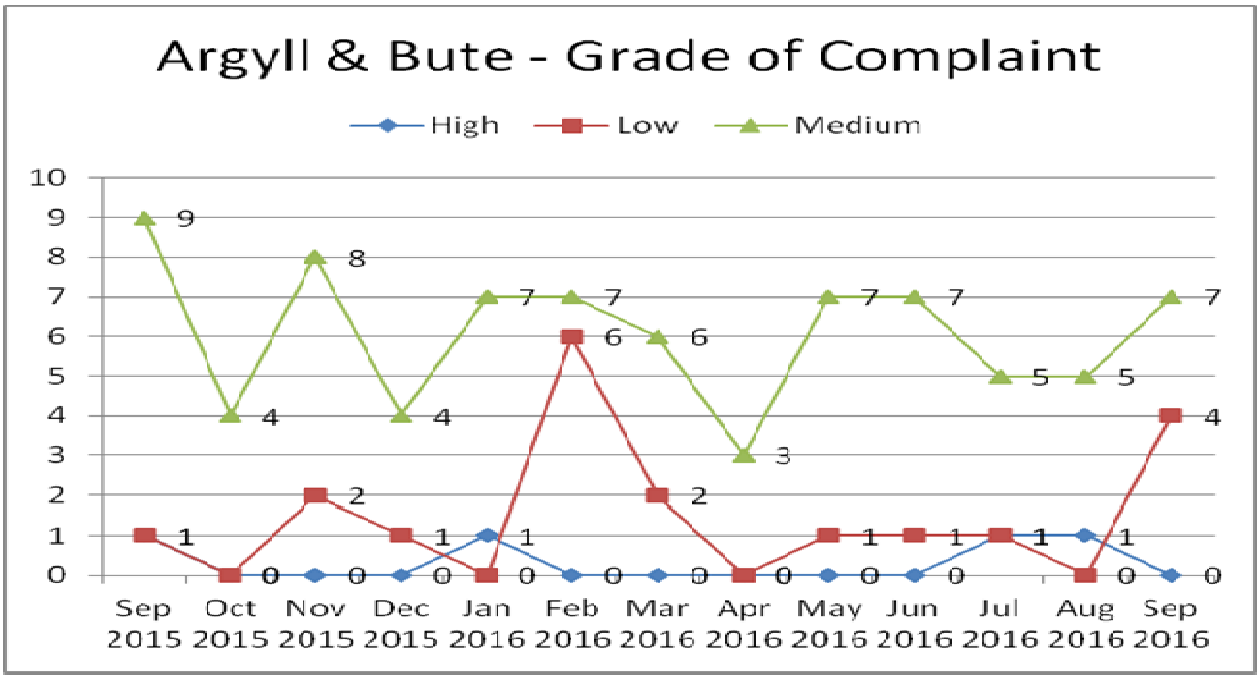


Figure 3: Health Complaint Issues September 2015 – September 2016

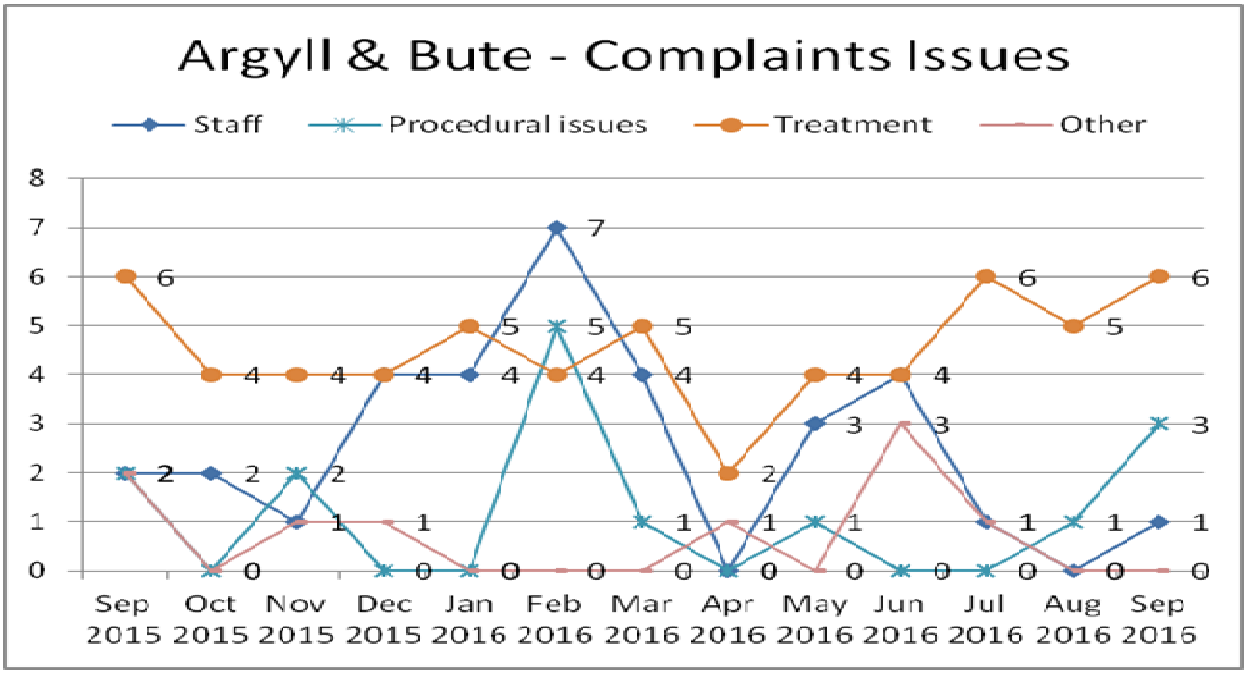
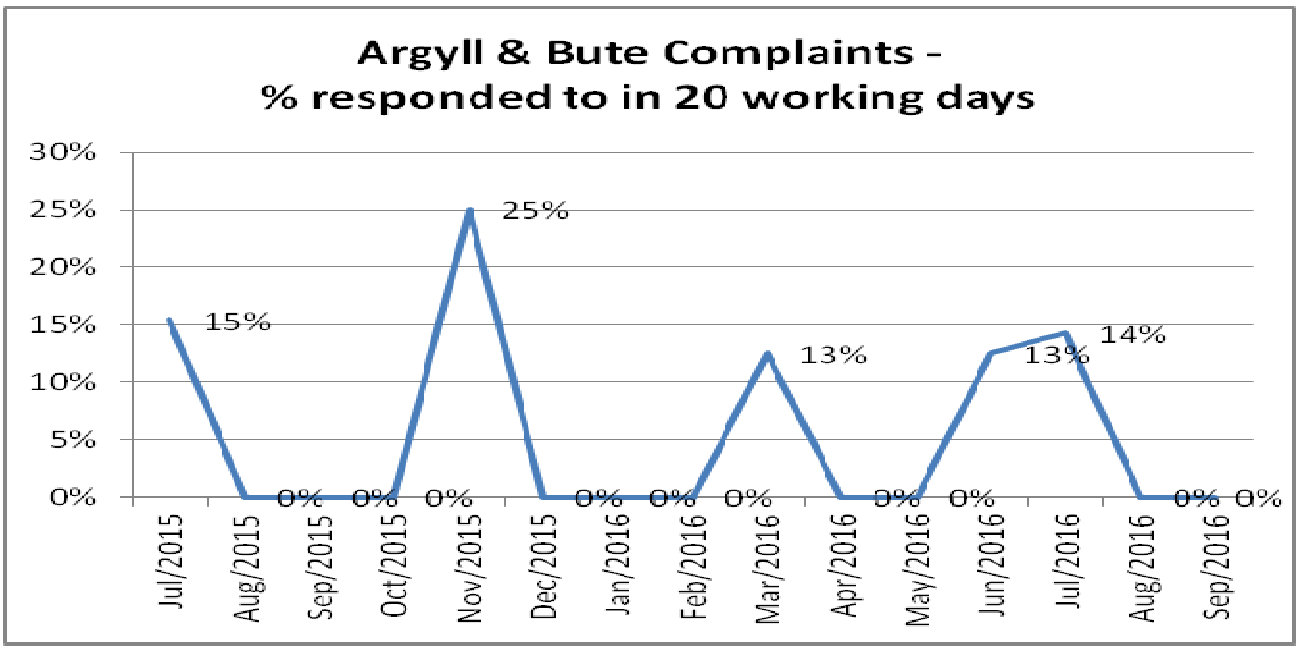


Figure 4: Health Complaints Achievement of 20 Working Day Response Target September 2015 – September 2016



3.2.2 Social Work Complaints

Table 2: Social Work Complaints July – September 2016

HSCP Social Work Complaints	JULY	AUG	SEPT
Stage 1	1	4	2
Stage 2	1	2	1
Overall - achievement for Stage 2 against 4 week target	0%	0%	0%
Total	2	6	3

Work is continuing in relation to developing reporting for HSCP Health complaints and Social Work complaints.

The RPIW event to improve performance has been postponed. Discussion about interim measures for improvement is planned.

3.3 KEY ISSUES CURRENTLY BEING PROGRESSED

Lorn and Islands Hospital (LIH) - Laboratory Services

Laboratory services are governed nationally by a number of bodies namely – MHRA (Medicines & Healthcare Products Regulatory Agency), Scottish Blood Transfusion Service (SBTS), UK Accreditation Service (UKAS) and Health and Safety Executive (HSE).

Since August this year the laboratory services in Oban have been subject to a number of inspections both formally or 'mock' inspections in preparation for formal inspections.

UKAS Inspection

In August 2016 UK Accreditation Service (UKAS) inspected LIH laboratory for ISO 15189 and CPA (Clinical Pathology Accreditation) which is a large list of quality assurance and competence standards. As a result of the inspection UKAS made 133 recommendations and CPA was suspended.
It is best practice to achieve ISO accreditation although not all laboratories have this. However full compliance with ISO standards is expected by 2017.

In response to the inspection results, external support has been commissioned to support the local team to deliver the required actions to be compliant and to prepare an options appraisal for longer term sustainability, exploring a 'network' or shared services approach.

Work is ongoing within the Oban Laboratory to address the 133 recommendations. Evidence of action taken in relation to CPA has to be submitted to UKAS by December 2016 in preparation for a repeat inspection in January 2017.

Mock MHRA Inspection

Following the UKAS inspection, LIH invited the Scottish Blood Transfusion Service (SBTS) to carry out a mock MHRA inspection as this was likely to be triggered following the UKAS inspection and the team wished to be abreast of any shortcomings and be prepared. The Mock MHRA inspection, carried out by SBTS took place on 3rd – 4th October 2016 and a written report was received on 10th October 2016.

This inspection raised concerns regarding the inclusion of inaccurate information in the annual audit submissions and actions from a previous inspection which had not been completed. The inspectors, when asked, felt that the transfusion practice was safe, but that it was not backed up by evidence of audits and quality management. A corrective action plan has been submitted to MHRA.

HSE Inspection Containment Level 3 Laboratories

A routine inspection visit took place on 03 November; a written report from HSE is awaited. Initial verbal feedback from HSE at the end of the visit was that overall the visit went well. HSE inspection visits to Containment Level 3 Laboratories take place every 3-4 years. The previous inspection of Oban Laboratory took place in 2012.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)

In addition HSE will undertake a separate visit to the LIH Laboratory on 16 November as a result of a RIDDOR reportable incident involving one member of laboratory staff. A local investigation has already taken place and corrective measures taken.

A number of recommendations and actions to address the issues identified from all of the laboratory inspection reports are being progressed with the locality, NHS Highland and NHS Greater Glasgow & Clyde.

Lorn and Islands Hospital - Hospital Standardised Mortality Ratio (HSMR)

NHS Highland was informed by Health Care Improvement Scotland (HIS) earlier this year that both Raigmore and Belford Hospitals were showing an upward shift in their HSMR data. For the period Jan-March 2016 The Belford Hospital HSMR figures were significantly higher than the Scottish average.

More recently, the HSMR data for Lorn & Islands Hospital was noted to be increasing; specifically the most recent data points are all above the median when plotted on a run chart.

Following notification of the Belford data, NHS Highland, working very closely with HIS, carried out a comprehensive case note review and has been able to gain assurance from the review in regards to care within the hospital.

Further scrutiny and improvement work is ongoing and NHS Highland continues to work closely with Health Care Improvement Scotland to identify the reasons for the increase in the HSMR figures

NHS Highland is taking a pan-Highland approach to mortality. A Board-wide HSMR Short Life Working Group, chaired by the Medical Director, has been established. All four acute hospitals are linked into this.

The following actions have been identified:

- Case note reviews of actual deaths that have contributed to the observed death in the HSMR measurement using the Structured Judgement Review (SJR) tool will be carried out.
- A review of the effect of patients admitted for end of life care on HSMR data.
- A review of the effect of deficiencies in administrative recording and/or quality of coding on predicted mortality
- A review of safety improvement at operational delivery.

NHS Highland have submitted improvement action plans to HIS for each of the four acute Hospitals.

Training has taken place with 4 staff from Lorn & islands Hospital to complete the new Structured Judgement Tool that is used when reviewing case notes. This replaces the trigger tool previously used by SPSP.

Plan

1. Develop local HSMR Short Life Working Group.
2. Identify support from HSCP for a clinical improvement post for Lorn & Islands Hospital short term. (5-6mths)
3. Identify additional staff to complete training on Structured Judgement Tool.
4. Carry out an independent review of 15 case notes from Lorn & islands Hospital.
5. Identify Consultant lead - Dr Elzbieta Tolloczko, Consultant Surgeon, has taken on this role.
6. Findings from independent review of case notes discussed with Senior Medical staff.
7. Develop a Quality & Safety Improvement Wall for local managers at Lorn & Islands Hospital
8. Develop Driver Diagram to reduce HSMR for Lorn & Islands Hospital.
9. NHS Highland High Level Mortality Reduction Driver Diagram for the 4 Acute Hospitals in place.
10. Review administrative recording and quality of coding within Lorn & Islands hospital. A report has been provided by the Public Health Intelligence Unit on the use of symptom vs. diagnostic coding. Training required.

Craigard Care Home, Bute / Care Home Governance

The Care Inspectorate undertook an unannounced visit to Craigard Care Home on Bute on 20 -21 September 2016. As a result of the visit the Inspector raised concerns on a number of issues including staff training, medication management and care planning.

Craigard Care Home on Bute provides residential accommodation for a maximum of 16 residents: at present the Health & Social Care Partnership (HSCP) has placed 13 residents in Craigard.

As a result of the issues raised the health and social care teams within the locality have been working with the management of the care home and the Care Inspectorate to implement an improvement plan to address the key concerns from the inspection.

To support the implementation of the HSCP action plan, a core group was established which meets weekly to monitor and review progress. The core group consists of the following disciplines – social work adult care, performance improvement, community nursing, and Craigard management team.

The HSCP management continue to work closely with the Care Inspectorate and the Care Home management and the action plan is being closely monitored and assurance on improvement work sought. This is the current position at the time of writing this report however this is an evolving situation therefore further verbal updates may be available at the IJB.

Updated 22 November 2016 - Escalation of Concerns at Craigard

The Care Inspectorate have secured the removal of Craigard's registration to provide care home placements at their establishment on Bute. On Monday, 21 November 2016, the Court granted the removal of the owner's registration to provide placements for its current residents. Despite the joint efforts of the Care Inspectorate and HSCP staff to assist the owner and staff group to meet the improvement actions set out by the Care Inspectorate. Inspectors formed a view that the care home would not meet the improvement requirements set out within the action plan within the agreed timescales.

The Court has set a date for the 9 December 2016 for the removal of the care home's registration. The Health and Social Care Management Team are now working with the residents and their families to identify alternative placements.

Reviews

A series of reviews have now been organised to secure new placements. The Management Team are using Cosla Best Practice guidelines in relation to the work that needs to be completed to secure appropriate placements based on the current needs of each resident. The Best Practice guidelines set out the steps that need to be taken to ensure residents and their families are involved in this process. There is clearly a significant time pressure around this work and care managers are actively planning and securing appropriate placements in partnership with the residents and their families.

There are a number of different placements currently being considered by families which include care homes in Inverclyde, Glasgow, Bute, Cowal and Erskine.

The Head of Adult Services (East) is overseeing this work and is providing a weekly update to the Chief Officer, Chief Executive, Chief Social Work Officer, Lead Nurse, local Elected Members, IJB Members and MSP. The HSCP managers based on Bute are in daily contact with the residents at Craigard as the work to find suitable alternative placements progress. The team continue to work closely with Care Inspectorate staff.

Care Home Governance

There are a number of existing mechanisms in place to monitor the standards of care across care homes in Argyll and Bute.

The Council's commissioning team work with local area managers to visit care homes on a regular basis to discuss current issues with care home managers and offer assistance and advice in terms of maintaining and improving care standards.

Quality in Care Home Assurance Groups are in place for Cowal and Bute, Helensburgh, Oban and Mid Argyll. These groups have recently been reviewed to ensure focus is placed on achieving, maintaining and improving care standards. These locality groups are chaired by Scottish Care Reps and a wide range of managers/staff attend these meetings which include Inspectors from the Care Inspectorate. The initial focus of these groups was on adult support and protection issues but the groups now have a wider improvement focus and care home managers are now being invited to attend these meetings. These changes are relatively new and will need to be monitored closely.

The HSCP Strategic Management Group believe that the responsibility for maintaining and improving standards in care homes needs to be owned by staff in all care sectors.

It is proposed that sessions are organised in localities twice a year to bring together those staff that currently have an active role with care homes. The purpose of these sessions will be to share learning and develop ideas to improve our ability to anticipate if a particular care home develops issues that are likely to have a negative impact on the standards of care being delivered to residents. These sessions will add to the governance already in place and can be repeated on an annual basis.

4 CONTRIBUTION TO STRATEGIC PRIORITIES

Robust governance arrangements are key in the delivery of strategic priorities.

5 GOVERNANCE IMPLICATIONS

5.1 Financial Impact
Potential for financial impact

5.2 Staff Governance
Staff governance issues highlighted in the report

5.3 Clinical Governance
Significant issues identified if not addressed urgently.

6 EQUALITY & DIVERSITY IMPLICATIONS

There are no equality and diversity implications

7 RISK ASSESSMENT

Risks articulated within the report.

8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

The membership of the Clinical and Care Governance Committee and the Health and Safety Group includes public representation

9. CONCLUSIONS

The report provides updates and information about some key areas of work in relation to clinical and care governance.

Risk Assessment Tool – Complaints

The Risk Assessment Tool adopts a three-step process which firstly categorises the consequences of a complaint, then assesses the likelihood of recurrence of the incidents or events giving rise to the complaint. Finally, a risk level is assigned to the complaint.

1.0 Consequence Categorisation Table

The following table assists in determining how to categorise the consequences of a complaint, or the subject matter of a complaint

Category	Description
Extreme	Issues regarding serious adverse events, long-tem damage, grossly sub-standard care, professional misconduct or death that require investigation. Serious patient safety issues. Probability of litigation high.
Major	Significant issues of standards, quality of care or denial of rights. Complaints with clear quality assurance or risk management implications, or issues causing lasting detriment that require investigation. Possibility of litigation.
Moderate	Unsatisfactory patient experience / outcome with short term effects. Slight potential for litigation. Some disruption to service delivery or ongoing problems with staffing levels.
Minor	Unsatisfactory patient experience / outcome directly related to care provision. Readily resolvable. No real risk of litigation Short term disruption to service with minor impact on patient care. Ongoing low staffing levels reducing patient quality.
Negligible	Reduced quality of patient experience / outcome but not directly related to delivery of clinical care. Interruption to service which does not impact delivery of care. Short term staffing levels which temporary reduces service quality (less than a day).

2.0 Likelihood Categorisation Table

The following table assists in determining the likelihood of recurrence of the incident of circumstances giving rise to the complaint.

Likelihood	Description
Almost certain	Recurring – found or experienced often.
Likely	Will probably occur several times a year.
Possible	Happening from time to time – not constant, irregular
Unlikely	Rare – unusual but may have happened before .
Rare	Isolated or one-off – slight/vague connection to healthcare service provision

3.0 Risk Matrix

Having assessed the consequence and likelihood categories using the tables above, the risk assessment matrix below can be used to determine the level of risk that should be assigned to the complaint.

LIKELIHOOD	CONSEQUENCES / IMPACT				
	Negligible	Minor	Moderate	Major	Extreme
Almost Certain	MEDIUM: 5	HIGH: 10	HIGH: 15	VERY HIGH: 20	VERY HIGH: 25
Likely	MEDIUM: 4	MEDIUM: 8	HIGH: 12	HIGH: 16	VERY HIGH: 20
Possible	LOW: 3	MEDIUM: 6	MEDIUM: 9	HIGH: 12	HIGH: 15
Unlikely	LOW: 2	MEDIUM: 4	MEDIUM: 6	MEDIUM: 8	HIGH: 10
Rare	LOW: 1	LOW: 2	LOW: 3	MEDIUM: 4	MEDIUM: 5

4.0 Action Required Based on Risk Assessment

- Remember that the grade may change if further information comes to light
- Always consider if there are lessons to be shared across the organisation

Action to be Taken	
Very High	Alert – Patient Focus Manager and Head of Clinical Governance and Risk Management/Clinical Governance Development Manager. Decide whether Legal Officer needs to be notified if potential claim. Should an early meeting with the complainant being arranged? All Complaints Officers need to be aware of these complaints. If it is unlikely that the complaint will be completed within 20 working days, letter should be sent out explaining situation, with a target date for completion. Closely monitor progress of complaint and ensure that the response is reviewed prior going over to the Chief Operating Officer for signing. All complaints of this grade if upheld or partially upheld should have recommendations and actions. These need to be logged and followed up.
High	Alert – Patient Focus Manager. Monitor progress of the complaint. All complaints of this grade if upheld or partially upheld should have recommendations and actions. These need to be logged and followed up.
Medium	Deal with as per normal process. If any recommendations and actions identified these need to be logged and followed up.
Low	Deal with as per normal process. If any recommendations and actions identified these need to be logged and followed up.

Argyll & Bute Health & Social Care Partnership

Integration Joint Board **Agenda item : 5.3**

Date of Meeting : **30 November 2016**

Title of Report : **Infection Prevention and Control**

Report prepared by: **Liz Higgins, Lead Nurse and Sheila Ogilvie, IPC Nurse**

Presented by : **Liz Higgins**

The Integration Joint Board is asked to :

- **Note the performance position for the HSCP**
- **Note the progress to reduce and mange healthcare associated infections**

1. EXECUTIVE SUMMARY

The purpose of this paper is to update Board members of the current status of Healthcare Associated Infections (HAI) and Infection Control measures in NHS Highland including Argyll & Bute HSCP.

2. INTRODUCTION

Staphylococcus aureus is an organism which is responsible for a large number of healthcare associated infections, although it can also cause infections in people who have not had any recent contact with the healthcare system. The most common form of this is meticillin Sensitive *Staphylococcus Aureus* (MSSA), but the more well known is MRSA (meticillin Resistant *Staphylococcus Aureus*), which is a specific type of the organism which is resistant to certain antibiotics and is therefore more difficult to treat. More information on these organisms can be found at:

http://www.nhs.uk/conditions/staphylococcal-infections/Pages/Introduction.aspx

NHS Boards carry out surveillance of *Staphylococcus aureus* blood stream infections, known as bacteraemias. These are a serious form of infection and there is a national target to reduce them. Information on the national surveillance programme for *Staphylococcus aureus* bacteraemias can be found at:

http://www.hps.scot.nhs.uk/haiic/sshaip/publicationsdetail.aspx?id=30248

The target for 2016/2017 for NHS Highland is 24.0 cases or less per 100,000 acute occupied bed days for *Staphylococcus aureus* bacteraemia (SAB) including MRSA. For NHS Highland this means no more than approximately **60 cases** by 31st March 2017.

All SABs, whether of hospital or community onset, are subject to Root Cause Analysis undertaken by the relevant clinicians and Infection Control Team. Any learning points identified are communicated to all clinical teams via the Cleanliness, Hygiene and Infection Control Committee.

Trends
NHS Highland's SAB incidence rate for April–June 2016 is 25.3 per 100,000 acute occupied bed days.

NHS Highlands position as of 31st August 2016 (data not yet validated by HPS) is **37 cases**

Argyll & Bute HSCP 's position as of 31st Oct 2016 is **4 cases** - detailed below

1 April – 31 Oct 2016	**MSSA = 4** **MRSA = 0** **Total SABs = 4**	All 4 patients had community onset infection. All were over 65 years old and 2 were diabetic. 2 subsequently died following transfer to tertiary care. One has fully recovered and the other remains in hospital (admitted 27Oct16). Following root cause analysis by the clinical and Infection Control teams, none of the infections were considered preventable and no learning points were identified.

***S. aureus* bacteraemia; Argyll & Bute; April 2013-March 2016**

YEAR	MSSA	MRSA	TOTAL
2013-2014	3	2	5
2014-2015	2	0	2
2015-2016	8	0	8

NB: The apparent rise in 2015 onward may be attributable to improvements in staff awareness, surveillance systems and reporting to the Infection Control Team

Clostridium difficile is an organism which is responsible for a large number of healthcare associated infections, although it can also cause infections in people who have not had any recent contact with the healthcare system. More information can be found at: http://www.nhs.uk/conditions/Clostridium-difficile/Pages/Introduction.aspx
NHS Boards carry out surveillance of *Clostridium difficile* infections (CDI), and there is a national target to reduce these. Information on the national surveillance programme for *Clostridium difficile* infections can be found at:
http://www.hps.scot.nhs.uk/haiic/sshaip/ssdetail.aspx?id=277

***Clostridium difficile* HEAT Target**

The target for 2016/2017 for NHS Highland remains as approximately 32.0 cases or less in patients aged 15 and over per 100,000 total occupied bed days. For NHSH this means no more than **78 cases** by March 2017

Trends

NHS Highlands position for Clostridium difficile infections as of 1st April 2016 to 31st August 2016 (data not yet validated by HPS) is **23 cases**

Argyll & Bute HSCP position as of 31st Oct 2016 is **6 cases** -detailed below.

1 April – 31 Oct 2016	Total CDI cases = 6	Classifications: Healthcare Associated = 2 Community Acquired = 4 Unknown= 0 Under Investigation = 0

CDI Argyll & Bute; April 2013 – March 2016

Year	Healthcare Assoc	Community	Total
2014-2014	12	7	19
2014-2015	8	6	14
2015-2016	6	4	10

Hand Hygiene Reporting

Good hand hygiene by staff, patients and visitors is a key way to prevent the spread of infections.
More information on the importance of good hand hygiene can be found at:
http://www.washyourhandsofthem.com./
http://www.washyourhandsofthem.com./documents/hand-hygiene-and-nhs-scotland/your-5-momentsfor-hand-hygiene/5-moments-credit-card.aspx
Each Board is responsible for monitoring and reporting hand hygiene compliance data.

NHS Highland Hand Hygiene Rolling Monthly Audit Programme continues across all clinical areas, and compliance rates are being sustained above the 95% target.

Details of Argyll & Bute Hand Hygiene compliance can be found at the end of this report

Cleaning and the Healthcare Environment

Keeping the healthcare environment clean is essential to prevent the spread of infections.
Information on national cleanliness compliance monitoring can be found at:
http://www.hfs.scot.nhs.uk/online-services/publications/hai/
Healthcare environment standards are also independently inspected by the Healthcare Environment
Inspectorate. More details can be found at:
http://www.nhshealthquality.org/nhsqis/6710.140.1366.html
Each Board is responsible for monitoring and reporting the cleanliness of hospitals.

Current Rates

The monthly cleaning and estates audits, conducted as per the National Cleaning Services Specification and through the use of Synbiotix© (the Facilities Management Scotland webbased audit tool), demonstrate compliance rates are being sustained above the locally defined targets (92% domestic monitoring and 95% estates monitoring). The previous quarterly rates (April to June 2016) identify averages of 97% for domestic monitoring, and 98% for estates across NHS Highland. Any areas identified during the audits, as requiring action are reported immediately to the relevant person.

A series of unannounced Independent Public Peer Review audits has commenced across NHS Highland.

***Escherichia coli* (E. Coli) Bacteraemia surveillance**

As of 1st of April 2016 the surveillance of *Escherichia coli* (E. Coli) Bacteraemia became a mandatory requirement for all NHS Boards to undertake. Data is collected by the Infection Prevention and Control Team in conjunction with the relevant clinical teams, and cases discussed to identify learning. This data will be published within the Quarterly report on the surveillance of Staphylococcus aureus bacteraemia (SAB) and the Surveillance of Clostridium difficile infection (CDI) in Scotland, and the next report is due at the end of October 2016.

Since April 2016, **15 patients** with *E. coli* bacteraemia have been admitted to hospital in Argyll & Bute and undergone enhanced infection surveillance. 2 of these infections could be attributed to healthcare interventions, while 11 had no associated healthcare intervention. In 2 patients, the source of infection could not be ascertained. The most common source of *E.coli* bacteraemia was infection of the urinary tract.

IC Net

The ICNet software continues to be used for all clinical record keeping by the Infection Control Team. In the absence of the live data uploads from labs in Oban, Paisley and Glasgow, the team remains reliant on paper copy reports from Oban lab, verbal reports from both clinical teams who send samples to Paisley and Glasgow, and relaying of ECOSS reports from the Health Protection Team in Inverness. The risk of such a person dependent system is documented on the Risk Register.

There has been a test of the live data feed successfully carried out and it is hoped the full functionality of ICNet will be up and running by end Nov 2016. This will negate the risk of reports being missed by the the Infection Control team and substantially improve the detection of developing outbreak situations.

Healthcare Associated Infection Reporting Template (HAIRT)

The following section is a series of 'Report Cards' that provide information, for all hospitals in Argyll & Bute, on the number of cases of *Staphylococcus aureus* blood stream infections and *Clostridium difficile* infections, as well as hand hygiene and cleaning compliance.

Understanding the Report Cards – Infection Case Numbers
Clostridium difficile infections (CDI) and *Staphylococcus aureus* bacteraemia *(SAB)* cases are presented for each hospital, broken down by month. SAB cases are further

broken down into Meticillin Sensitive Staphylococcus aureus (MSSA) and Meticillin Resistant Staphylococcus aureus (MRSA).

For each hospital the total number of cases for each month, been reported as positive from a laboratory report, on samples taken more than 48 hours after admission.

Understanding the Report Cards – Hand Hygiene Compliance
Hospitals carry out regular audits of how well their staff are complying with hand hygiene. Each report card presents the combined percentage of hand hygiene compliance with both opportunity taken and technique used broken down by staff group.

Understanding the Report Cards – Cleaning Compliance
Hospitals strive to keep the care environment as clean as possible. This is monitored through cleaning and estates compliance audits.

Healthcare Associated Infection Report Cards

NHS HIGHLAND ARGYLL & BUTE HOSPITALS REPORT CARD

- Argyll & Bute Hospital Lochgilphead
- Oban, Lorn & Islands Hospital

The Community H ospitals covered in this report card include:

- Campbeltown Hospital
- Cowal Community Hospital, Dunoon,
- Dunaros Community Hospital, Isle of Mull
- Islay Hospital
- Mid Argyll Community Hospital & Integrated Care Centre, Lochgilphead
- Victoria Hospital & Annex, Rothesay

***Staphylococcus aureus* bacteraemia monthly case numbers**

	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16
MRSA	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	1	0	0	0	2	0	0	0	0	1	0	0	1	1
TOTAL SABS	1	0	0	0	2	0	0	0	0	1	0	0	1	1

***Clostridium difficile* infection monthly case numbers**

	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16
Ages 15-64	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ages 65 plus	0	0	0	1	1	0	0	0	0	0	1	0	2	1
Ages 15 plus	0	0	0	1	1	0	0	0	0	0	1	0	0	0

Hand Hygiene Monitoring Compliance (%)

	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16
TOTAL	100	97	97	97	98	97	99	95	96	100	98	98	99	99
AHP	100	90	100	100	100	95	100	100	100	100	100	93	100	100
ANCILLARY	100	100	100	96	100	93	100	90	96	100	100	100	100	100
MEDICAL	100	100	90	94	94	100	95	91	86	100	93	100	100	100
NURSE	99	99	99	99	99	100	100	100	100	98	97	100	99	97

Cleaning Compliance (%)

	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16
TOTAL	97	96	97	96	96	97	100	96	97	97	98	97	97	95

Estates Monitoring Compliance (%)

	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16
TOTAL	96	94	97	97	93	97	100	97	98	98	98	99	98	96

4. CONTRIBUTION TO STRATEGIC PRIORITIES

Robust infection control arrangements are key in the delivery of safe and appropriate care.

5. GOVERNANCE IMPLICATIONS

5.1 Financial Impact

Inadequate infection control governance has a potential financial impact in respect of avoidable treatments and lengths of stay in hospitals.

5.2 Staff Governance

Significant staff governance concerns if issues not addressed

5.3 Clinical Governance

Significant if risks identified not addressed urgently

6. EQUALITY & DIVERSITY IMPLICATIONS

None.

7. RISK ASSESSMENT

Risks articulated within the report.

8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

Public involvement on CHIC meetings and in peer audits.

9. CONCLUSIONS

The Infection Prevention and Control service within Argyll &Bute ensures there is a robust system in place for infection surveillance and support. The risk within the service are well articulated and managed and this is borne out by the current infection rates and response to incidents.

The team have integrated well with the NHSH wide team and work together to mitigate for risks created by lack of IT system to support practice. The Infection Control Nurses are well supported by the microbiology team in Raigmore, and in particular by Dr Jonty Mills in his role as Infection Control Doctor. Dr Mills has recently relinquished the role of ICD and the team wish to record their thanks to him for his professional advice and leadership. The role of ICD has now been assumed by Dr Vanda Plecko.

Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Agenda item : 5.4

Date of Meeting : **30 November 2016**

Title of Report : **HSCP Strategic Risk Register**

Prepared by: **Fiona Campbell, Clinical Governance Manager &**
Julian Gascoigne, Risk / Health and Safety Manager

Presented by : **Liz Higgins, Lead Nurse**

The Integration Joint Board is asked to:

- Note the attached Strategic Risk Register

1. EXECUTIVE SUMMARY

It is a requirement of the Scheme of Integration and the Partnership's Risk Management Strategy that the Partner Bodies develop shared risk registers that will identify and record risks related to the delivery of services under integration functions.

The attached Strategic Risk Register records the prioritised high and very high risks from the service registers.

2. INTRODUCTION

The Partnership's Risk Management Strategy sets out a framework and arrangements for identifying, assessing, prioritising and recording risks relating to the delivery of services within the Partnership.

Members of the Strategic Management Team are required to develop and maintain service risk registers to record any risks which could impact on the delivery of each service. For each risk; the nature of the risk, the level of risk and action required to reduce the risk to a reasonable level is identified.

All the high and very high risks from the service risk registers are escalated to the Chief Officer to ensure that these risks are reviewed, controlled and managed appropriately.

Risk registers within the Partnership are continuing to be developed. The Clinical Governance team/ Health and Safety Team is supporting managers to ensure that registers are fully populated and the risk register processes are embedded.

When the Strategic Risk Register is next reviewed by the IJB, the risk registers; risk register processes and communication between registers will be fully developed.

3. DETAIL OF REPORT

It is a requirement of the Risk Management Strategy that the Strategic Risk Register is reported to the IJB every six months for oversight. The current Strategic Risk Register is attached.

4. CONTRIBUTION TO STRATEGIC PRIORITIES

The Risk Register processes contribute to the following strategic objectives.

(B) We plan and provide health and social care services in ways that keep them safe and protect people from harm

(J): We will put in place a strategic and operational management system that is focused on continuous improvement, within a clear governance and accountability framework.

5. GOVERNANCE IMPLICATIONS

5.1 Financial Impact

No additional resource is being utilised to produce the Strategic Risk Register. Financial implications may arise if the risks are not managed effectively across the Partnership.

5.2 Staff Governance

The Strategic Risk Register is reported to the IJB which has staffside representation from both partner bodies.

5.3 Clinical Governance

Risk management is an integral part of clinical governance and it is essential that risks are identified and managed in order to ensure the safety of our staff and patients and to ensure that our governance arrangements are effective.

6. EQUALITY & DIVERSITY IMPLICATIONS

None

7. RISK ASSESSMENT

There would be a significant risk of the HSCP failing to achieve its strategic objectives and meet its statutory obligations if risk was not managed on an ongoing basis.

8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

Public representatives are members of the IJB where the Strategic Risk Register is tabled.

9. CONCLUSIONS

The Strategic Risk Register provides the IJB with an overview of the strategic risks faced by the Partnership and the measures in place or identified to control these risks.

Argyll & Bute HSCP Strategic Risk Register

	Risk Ref	Date Added	Description of Risk & Source	Lead Risk Owner/ Committee	Current Control Measures	Risk Likelihood	Risk Severity	Risk Rating	Proposed New Controls (Action Plan inc Timescales)	Target Risk Likelihood	Target Risk Severity	Target Risk Rating	Target Date	Accept Risk/ Transfer?	Date Reviewed
1			Risks should be described as: There is a risk of x because of y resulting in z												
2	HR008	01/10/13	Failure to recruit to clinical rural posts, particularly GPs, due to isolation, onerous on call, lack of access to peer networks and requirement for extended skill set has a potential serious impact on the ability to deliver services.	Head of Strategic Planning & Performance	--SGHD funded Remote and Rural Initiative -Refresher training programme implemented, next programme Nov 2016 -NES Initiative -R&R programme in place -Develop effective and attractive recruitment materials	Almost Certain	Extreme	Very High	-Promote Argyll and Bute as a place to work -Explore obligate networks to reduce impact of isolation - New GP contract with quality clinical leads in development	Possible	Major	High	01/04/17		14/11/16
3	E-H 05	17/10/13	Lack of connectivity between the TrakCare instances of NHS Highland and NHS GG&C because of the departure from the NHS Highland PMS Business Case leading to perpetuation of inequity of access / priority for Argyll & Bute patients / potential delay in treatment and resultant outcome. This is formally recorded as risk 54 in the NHS Highland PMS Programme Risk Register	Stephen Morrow / eHealth	SLA operational group.	Almost Certain	Major	Very High	Establishing an A&B and GG&C planning group for service and e-health supporting the development of the HSCP, first meeting Dec 2016.	Possible	Moderate	Medium	01/04/17		14/11/16
4	Assoc Med Dir CD-01	17/10/16	Risk of Employing locum consultants and GPs due to vacant posts/absent clinicians resulting in higher costs/financial impact and potential reduced standards of care due to potential lack of continuity of care and familiarisation/ compliance with local clinical policy and procedure	Dr M Hall / Management Team /Clinical forum	-Remote and Rural initiative. - NHSH advertising strategy including international.	Almost Certain	Major	Very High	-Review LIH Medical model and review group to be established, Failure to recruit to Consultant Physician vacancies remains an issue; service delivery change unlikely to change at present, but closer working with GG&C may help to reduce risk. Review of A&B hospital Consultant service delivery underway following RCPsych report and risks around the in patient facility and the staffing of that facility.	Possible	Moderate	Medium	01/10/17	Yes	17/10/16
5	MH Mod OR-22	11/10/13	Continued delay to the project programme due to cost exceeding budget requiring review of proposals resulting in a financial burden associated with maintaining A&B Hospital building, and an extended period of providing care in a building which is no longer fit for purpose.	Donald Watt	-Reviewing options for new build or refurbishment -3 Review Groups established: 1) Support Services 2) Clinical Services 3) Capital Programme	Almost Certain	Major	Very High	Interim move of inpatient mental health services to the lower ground floor of the Mid Argyll Community Hospital in progress with a completion date of March 2017. Ongoing clinical and support service review to ensure a safe and effective service is deliverable.	Possible	Moderate	Medium	01/10/16		11/10/16
6	Lead Nurse LN-01		Inability to deliver the health and social care that is required by older people and their carers due to demographic changes, financial pressures and disease profiles leading to increased need to adopt more anticipatory and preventative approach to care delivery for older people. This must be done in wide partnership across statutory, independent and third sector agencies and with local communities. The complexity of change needed is considerable and the time pressures are significant. The impact is that patients and carers receive suboptimal support and care.	Elizabeth Higgins, Lead Nurse	-Change programme continuing under ICF -Priority workstreams focussing on prevention, anticipation and reablement continuing -Extensive partnership engagement ocurring	Almost Certain	Major	Very High	-Strategic Plan HSCP continuing the Commissioning Strategy for Older People -Health and social care integration will focus on person centred care, building on individual and community assets through effective locality planning. Effective leadership framework will be developed to ensure those with the right skills of engaging leadership will influence and lead the ongoing transformation of services. Exploring and testing new models of care e.g. Buurtzorg model and neighborhood Team	Possible	Moderate	Medium	30/04/17		09/11/16

	Risk Ref	Date Added	Description of Risk & Source	Lead Risk Owner/ Committee	Current Control Measures	Risk Likelihood	Risk Severity	Risk Rating	Proposed New Controls (Action Plan inc Timescales)	Target Risk Likelihood	Target Risk Severity	Target Risk Rating	Target Date	Accept Risk/ Transfer?	Date Reviewed
7	Lead Nurse LN-02		Reduced clinical contact and professional networks between NHS GGC consultant obstetricians and NHSH local midwives due to working within different governance structures and changes to the Maternity Services SLA with NHS GGC. This is leading to more fragmented care pathways and less effective communication across the system which increases the clinical risk. Midwives must have the support and professional confidence in their relationships with consultants and staff in consultant led units to enable them to deliver services in rural and isolated areas	Elizabeth Higgins, Lead Nurse	-Regular SLA review meetings -Discussion between Senior Midwives and Consultants at locality level -Use of Keeping Childbirth Natural and Dynamic pathways -Workload and workforce review for maternity services in Argyll and Bute has been completed and data analysed. -Consultant midwife in post and has re-established links with referral hospitals in GGC & clinical risk midwife -Maternal and New-born Governance and Improvement Group established to focus on risk and governance between HSCP, NHS Highland and GGC.	Almost Certain	Major	Very High	-Future model in development to include governance and accountability for the service to ensure preservation of safe and effective pathways with NHS GGC. --Paper to address identified gaps currently being drafted to improve model communication and feedback. Meeting currently being arranged with GGC consultants to address risk	Possible	Minor	Medium	01/06/17		10/11/16
8	P&P 002	01/11/16	Aros and A&B Hospital estate not fit for purpose and unaffordable to maintain. Leading to a risk of poor service delivery and health and safety non-compliance	S Whiston/ L Patterson	Emergency reactive maintenance of current buildings. Established a site development board to oversee project to relocate staff/patients to suitable accommodation.	Almost Certain	Major	Very High	Transfer of patients and staff from West House and Succoth to ground floor of MACHICC and other areas. Site planning group developing a plan for the closure of Aros and transfer of staff to alternative accommodation. Option appraisal for future siting of mental health facility to be developed	Unlikely	Major	Medium	31/03/17		14/11/16
9	Lead Nurse LN-03	18/08/15	Delay or failure in ICNs being informed of infection due to inability to access real time microbiology data from Oban and GGC Labs in Paisley and Glasgow via IC Net resulting in spread of infectious outbreak; delay or failure to take appropriate actions; inaccurate surveillance data	Elizabeth Higgins, Lead Nurse	ICNet software being used by ICNs in Argyll & Bute but requires manual input. This allows data to be shared with others in the wider team. -Regular face-to-face communication with laboratory staff in Lorn & Islands Hospital -Regular face-to-face, telephone or email communication with staff in all Argyll & Bute Hospitals, with active enquiry re infection status of current inpatients. -Staff education re importance of notifying ICN of any suspected transmissible or healthcare associated infection. -Perusal of hard copy paper reports from Oban & QEUH, Glasgow labs - this is very time consuming as can be up to 100 reports per day -Alerts on PAS manually entered by ICNs to flag patients admitted who have known history of infection carriage - PAS is trawled for all hospital beds in A&B on most working days. -C. difficile results notified to Health Protection team in NHSH are forward to ICN in A&B as a cross check to the above	Almost Certain	Major	Very High	A test of the live data feed has been completed successfully andtarget for full implementation of ICNet by Nov 2016	Rare	Major	Medium	30/11/16		09/11/16

	Risk Ref	Date Added	Description of Risk & Source	Lead Risk Owner/ Committee	Current Control Measures	Risk Likelihood	Risk Severity	Risk Rating	Proposed New Controls (Action Plan inc Timescales)	Target Risk Likelihood	Target Risk Severity	Target Risk Rating	Target Date	Accept Risk/ Transfer?	Date Reviewed
10	Lead Nurse LN-04	29/04/16	Risk of conflicting or delayed advice being given to clinicians managing a Microbiology issue within Argyll & Bute HSCP due to 1. The pathways for Infection Control support being with NHS Highland whilst Microbiology advice pathway is via GG&C Health board when these two issues are often inextricably linked. 2. The resultant inadequate flow of all information including lab results and discussion outcomes. Resulting in possible delays or inaccurate treatment advice being given.	Liz Higgins	High vigilance levels by Infection Control staff and clinical staff Manual data collection and input of lab results Increased verbal and email communication pathways between members of NHSH IC team and Glasgow	Almost Certain	Major	Very High	ICNet being used to share information whilst awaiting live data feed (ICNs Nov 16) Datix reporting which results in increased awareness and vigilance (IC Staff/Clinical Staff on-going) Meeting required with GG&C to discuss way forward (Lead Nurse/Planing APRIL 17)	Likely	Major	High			09/11/16
11	P&P/ OR11	26/09/13	Risk of weak negotiating position with secondary care provider NHS GG&C due to inability to resolve funding shortfall leading to withdrawal or retrenchment of services and reduction in local access of specialist services -Potential high financial risk to Argyll and Bute & NHS Board relating to GG&C SLAs -Source: SLA Financial management meetings -SLA meeting correspondence & discussion between respective Board Executives	Stephen Whiston / George Morrison Monitored by Strategic Management Team	-SLA agreements and sign off of methodology -Monthly finance reports to management and IJB --HoF & HSPP monitor service performance on annual basis informed by regular operational & SLA meetings with GGC - New SLA being agreed reflecting HSCP commissioning intentions	Likely	Major	High	-New Cost & activity model proposed by GG&C as part of WoS RPG review. -Payment plan agreed SLA funding gap reduced to zero 2016/17. SLA being reviewed to reflect commissioning intentions to reduce unscheduled care activity and cost of SLA at locality level. Help address cost pressures and cost per case charging going forward.	Possible	Moderate	High	01/10/17		01/11/16
12	MAKI OR 05	26/09/13	Failure of SAS to respond to emergency calls and inter-hospital transfers because of limited availability of vehicles or crews that are fatigued, and temporary deployment in Glasgow resulting in deteriorating patient health.	LMs	-Ambulance control will allocate to nearest available crew -Clinical staff to DATIX issues related to SAS delays to ensure accurate record. -Regular meetings with SAS managers to highlight any locality issues in timely manner -Escalate to SMT if necessary -Monitor 4 hour A&E breaches due to delays in transport	Likely	Extreme	High	-Formal meeting with SAS Senior Management to review Datix reporting and outcomes	Possible	Major	High	01/04/16	Yes	21/10/16
13	CO 10	16/11/15	Expenditure exceeds available resources and therefore failure to achieve financial balance at the year-end. This would be as a result of cost and demand pressures and the ability to achieve savings targets.	Chief Officer / Chief Financial Officer	- Formal budget monitoring reports to SMT and the IJB - Quality and Financial Plan in place for 2016-17 including savings required to delivered balanced budget - Financial Recovery Plan in place to address forecast overspend position	Possible	Major	High	Financial Recovery Plan for 2016-17 includes: - Review of payment to Greater Glasgow and Clyde - Review spending plans against non-recurring funding allocations with a view to removing un-committed elements - Further efficiencies and cost reduction through vacancy management, management of sickness absence and standardisation of procurement processes - Drive forward re-design of community pathways and community hospital services - Review of future commitments on non-pay non-essential expenditure budgets - Restricting new investment to core service delivery	Unlikely	Moderate	Medium	31/03/17		08/11/16

	Risk Ref	Date Added	Description of Risk & Source	Lead Risk Owner/ Committee	Current Control Measures	Risk Likelihood	Risk Severity	Risk Rating	Proposed New Controls (Action Plan inc Timescales)	Target Risk Likelihood	Target Risk Severity	Target Risk Rating	Target Date	Accept Risk/ Transfer?	Date Reviewed
14	CFO	14/11/16	Reduction in funding available to deliver services, as a result of reduced financial allocations from partners and increasing cost and demand pressures from service delivery.	Chief Financial Officer	Effective framework for medium term financial planning which takes into account scenarios for funding. Ensure that IJB position is represented when communicating financial implications of policy decisions and demand for services to the Scottish Government.	Likely	Major	High	Further develop framework for medium and longer term financial planning. Ensure appropriate Quality and Financial Plan is developed in line with the agreed timetable to ensure the IJB can approve a balanced budget. Explore opportunities for targeted investment in areas in line with the delivery of the Strategic Plan.	Possible	Moderate	Medium	31/03/17		14/11/16
15	E-H05	01/11/16	On-going difficulties in accessing Council IT systems for NHSH sites and vice versa, leading to delays in service provision and risk of data being missed.	S Morrow	Range of manual and duplicate system workarounds in place.	Likely	Major	High	Agreed proposals for new systems in development and sharing of networks.	Possible	Major	High	01/10/17		14/11/16

Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Agenda item : 5.5

Date of Meeting: **30 November 2016**

Title of Report: **Argyll & Bute HSCP - Performance Report National Health and Well Being Outcome indicators**

Presented by: **Stephen Whiston, Head of Strategic Planning & Performance**

The Integration Joint Board is asked to:

- Note the performance against Outcome 3 and 4 for Quarter 2
- Note the progress in with regard to the HSCP performance against Outcome 3 and 4
- Note the action identified to address deficiencies in performance as detailed in the exception reports

1. Background

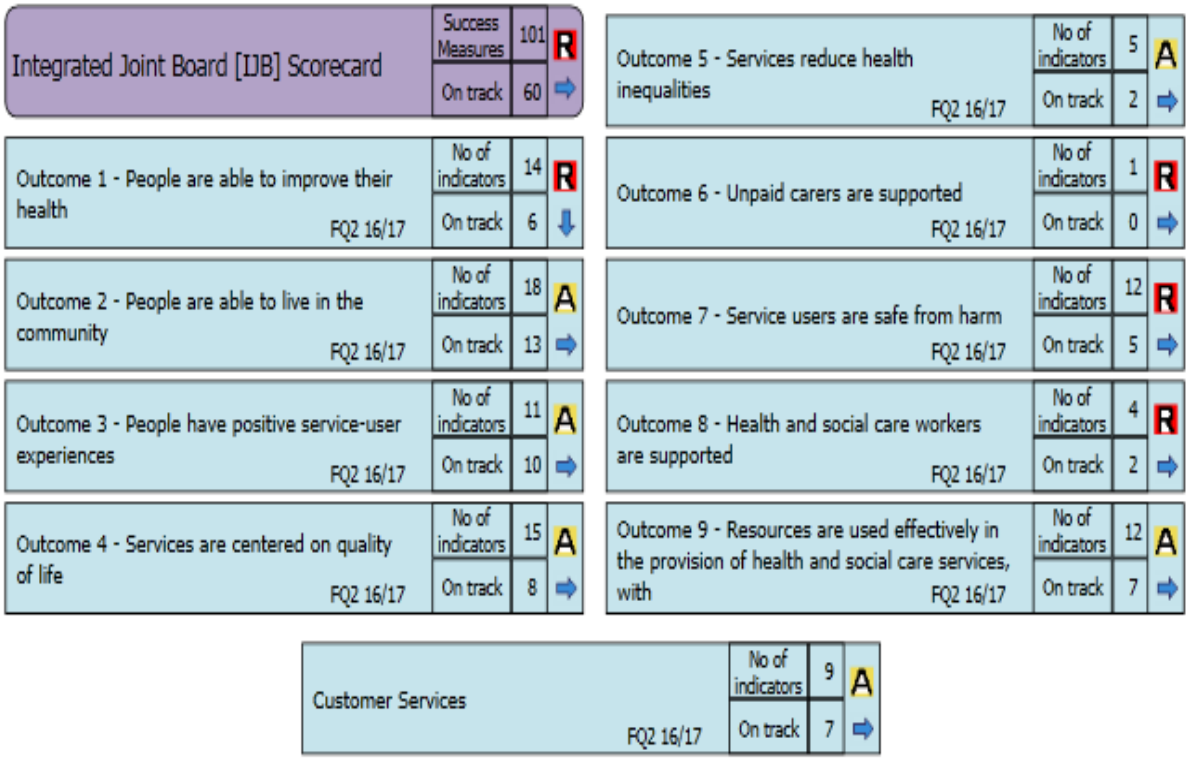
The national health and wellbeing outcomes provide a strategic framework for the planning and delivery of health and social care services. These suites of outcomes, together, focus on improving the experiences and quality of services for people using those services, carers and their families. These outcomes focus on improving how services are provided, as well as, the difference that integrated health and social care services should make, for individuals.

Currently there are 9 key National Health and Wellbeing Outcomes (NHWBO) and 23 sub-indicators which form the basis of the reporting requirement for the HSCP.

2. HSCP Performance against the NHWB outcomes for Financial Quarter 2 16/17

Table 1 below provides a Pyramid summary, noting the 101 scorecard success measures and of these 60 are currently reported as being on track for FQ2

Table 1



Members should note that due to the recent national release of missing data (e.g. annual returns) and new indicators supplied by the Scottish Government the number of indicators has increased from 93 to 101 which has resulted in a number of amendments to outcome measures. These changes have also had an impact on performance, the outcome measures are:

Outcome	Indicator
Outcome 1	• Premature Mortality rate • Rate of emergency admissions per 100,000 population for adults.
Outcome 2	• Emergency Admissions bed day rate (per 100,000 population) • Readmissions to hospital within 28 days of discharge (per 1000 population). • Proportion of last 6 months of life spent at home or in a community setting • Falls rate per 1,000 population aged 65+ • % of adults with intensive needs receiving care at home • % of health and care resource spend on hospital stays where the patient admitted in an emergency
Outcome 3	• % Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated • % Percentage of adults receiving any care or support who rate it as excellent or good
Outcome 4	• % Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life
Outcome 6	• % of carers who feel supported to continue in their caring role
Outcome 7	• % of adults supported at home who agree they felt safe

3 Detailed Performance Report Outcome Indicators 3 and 4

Outcome 3 - People are able to look after and improve their own health and wellbeing and live in good health for longer.

There are 11 indicators being measured against this outcome, 10 are on track, 1 is off track and red flagged.

- *No of patients with early diagnosis & management of dementia*

The exception report attached provides the detail of the performance against this indicator and the action in hand to rectify performance.

Outcome 4 - People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

There are 15 indicators being measured against this outcome, 9 are on track and 6 are off track and red flagged.

The report attached provides the detail of the indicators and the exception report for those indicators red flagged which are listed below:

- *Falls rate per 1,000 population aged 65+-*
- *Rate of emergency admissions per 100,000 population for adults*
- *% of health & care resource spend on hospital stays, patient admitted in an emergency*
- *No of outpatient ongoing waits >12 wks*
- *% of patients on the admissions waiting lists with social unavailability*
- *% of patients on the admissions waiting lists with medical unavailability*

4 Governance Implications

4.1 Contribution to IJB Objectives

The PPMF is in line with the IJB objectives as detailed in its strategic plan.

4.2 Financial

There are a number of NHWBO indicators which support the quality and financial performance of the HSCP including productivity, value for money and efficiency.

4.3 Staff Governance

A number of indicators under outcome 8 are pertinent for staff governance purposes

4.4 Planning for Fairness:

The NHWBO indictors help provide an indication on progress in addressing health inequalities.

4.5 Risk

Ensuring timely and accurate performance information is essential to mitigate any risk to the IJB governance, performance management and accountability.

4.6 Clinical and Care Governance

A number of the NHWBO indicators support the assurance of health and care governance and should be considered alongside that report

4.7 Public Engagement and Communication

A number of the NHWBO indicators support user and patient experience/assessment of the HSCP services and planning processes

Argyll & Bute Health and Social Care Partnership

Performance Exception Report for Integrated Joint Board
30th November 2016

Performance & Improvement Team

"People in Argyll and Bute will live longer, healthier, happier, independent lives"

Exception Reporting & Briefing Frequency

The Integrated Joint Board will receive this performance and exception report on a 6 weekly basis, this will be taken from a live snapshot of the current overall HSCP performance; focussing on those measures showing as below target performance. The layout of the report is designed to give IJB members a quick easy-read overview of exception across the IJB Scorecard, the format of the report uses the key aspects of the Pyramid Performance Management System in order to ensure continuity and consistency. Trend indicators are included within the report to ensure that performance variance and movement is reflected against the most recent reporting episodes.

This exception report format will be used to communicate performance across the HSCP and key stakeholders including its host bodies. The table below notes the groups and briefing frequency:

Group	Briefing Frequency
Local Authority –PR Committee	Quarterly
NHS Board	Quarterly
Community Planning Partnership *	Quarterly
Area- Community Planning Partnerships*	Quarterly

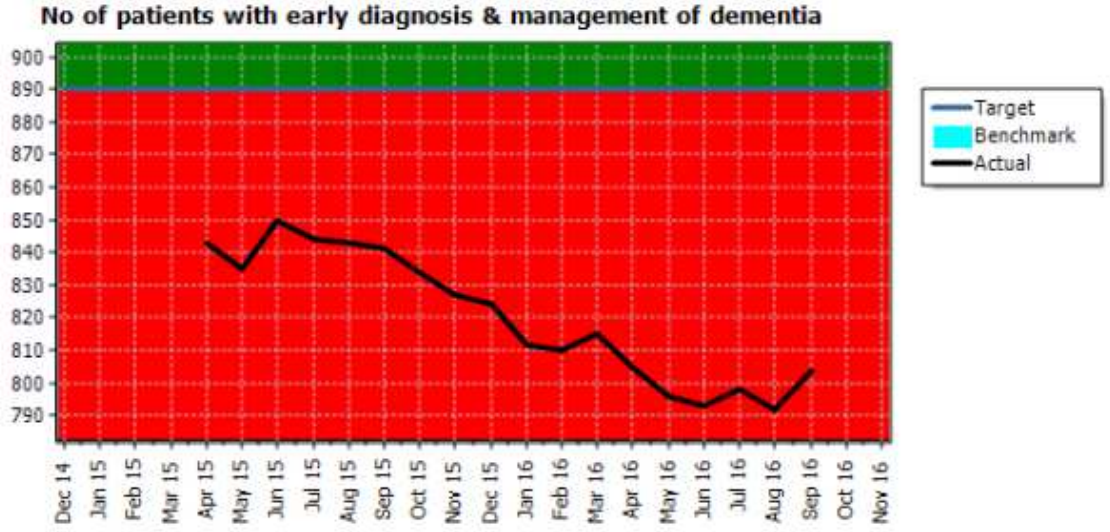
Performance Measure / Outcome		Target	Actual	Trend	Period	Responsible Manager
3	No of patients with early diagnosis & management of dementia	890	804	↑	FQ2	Lorraine Paterson
Performance Measure / Outcome		**Target**	**Actual**	**Trend**	**Period**	**Responsible Manager**
4	Falls rate per 1,000 population aged 65+	20	23	→	FQ2	Lorraine Paterson
4	Rate of emergency admissions per 100,000 population for adults	11,865	12,045	→	FQ2	Lorraine Paterson
4	% of health & care resource spend on hospital stays, patient admitted in an emergency	22%	23%	→	FQ2	Allen Stevenson
4	No of outpatient ongoing waits >12 wks	0	58	↓	FQ2	Lorraine Paterson
4	% of patients on the admissions waiting lists with social unavailability	15.7%	26%	↓	FQ2	Lorraine Paterson
4	% of patients on the admissions waiting lists with medical unavailability	2.0%	2.7%	↓	FQ2	Lorraine Paterson

Management Exception Reporting

Performance Indicator: Outcome 3 No of patients with early diagnosis & management of dementia	Responsible Manager: Lorraine Paterson
Target: 890 Actual: 804	Date of Report: FQ2

Description of Exception

(Consideration should be given when describing the nature of the exception with regards to previous trends, reasons for exception, external /internal influences on performance, previous action taken to address performance, actions current in place to improve performance)



The performance measure used for this standard is the number of people with a diagnosis of dementia on the Quality and Outcomes Framework (QOF) dementia register and other equivalent sources. The standard supports a commitment to achieve improvements in the early diagnosis and management of people with dementia. This should be supported by physical and mental health reviews every 15 months along with an assessment of carers needs which includes an appraisal of the impact of caring on the care giver.

Actions Identified to Address Exception and Improve Performance

(Consideration should be given when describing actions to address performance with regards what requires to be done, who is going to do it and how will this improve performance)

Following the abolition of QoF within the GP contract, there has been a fall in performance against this standard. The locality community dementia teams are continuing to support and advise primary care.

Scotland's National Dementia Strategy 2016-19. Was published in March 2016. The HSCP is now establishing a Dementia Programme Board recognising that work has stalled on this. The Board will be meeting on the 12th December 2016; the Board is chaired by the Lead Nurse.

It is expected that a suite of actions will be identified to address the deficiency in performance and will be monitored by the Programme Board and at locality level.

Actions Identified to Address Current /Future Barriers

(Consideration should be given when describing barriers with regards to, how are the barriers going to be managed, who will take this work forward)

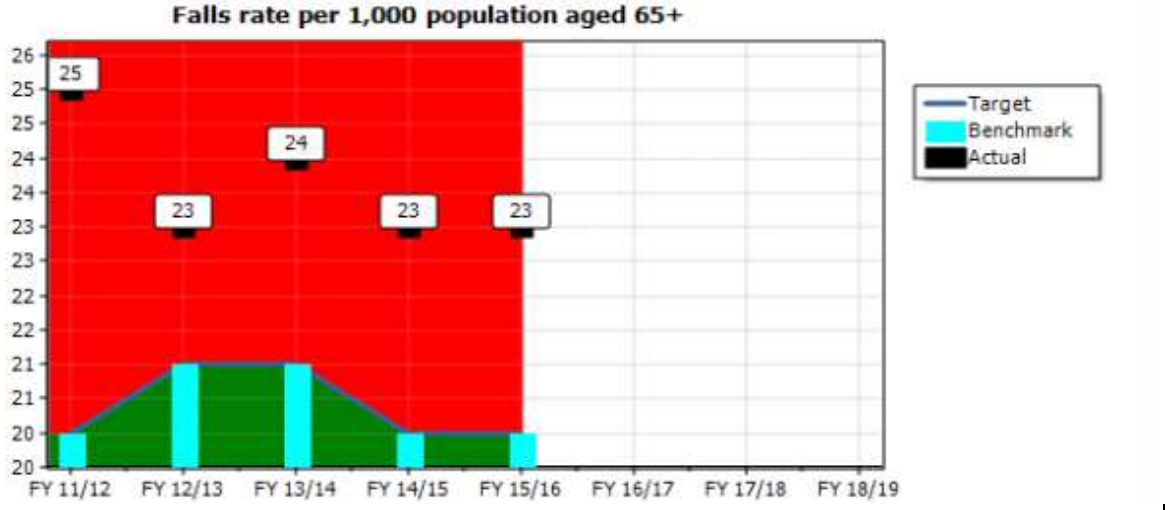
Additional Support Requirements Identified	
Improvement Forecast Date:	**Review Date:**
March 2017	monthly

Management Exception Reporting

Performance Indicator: Outcome 4 Falls rate per 1,000 population for adults aged 65+	**Responsible Manager:** Lorraine Paterson
Target: 20 Actual: 23	Date of Report: FQ2 16/17

Description of Exception

(Consideration should be given when describing the nature of the exception with regards to previous trends, reasons for exception, external /internal influences on performance, previous action taken to address performance, actions current in place to improve performance)



The indicator is measured using data gathered by Information Services Division (ISD) on the number of patients aged 65 plus who are discharged from hospital with an emergency admission code 33 - 35 and ICD10 codes W00 – W19.

Actions Identified to Address Exception and Improve Performance

(Consideration should be given when describing actions to address performance with regards what requires to be done, who is going to do it and how will this improve performance)

All localities are working through the National Framework for Action on the Prevention and Management of Falls in the community, and have supporting action plans. The HSCP Falls prevention advisor Dr Christine MacArthur is leading on this work working within localities

Level 1 screening postcards have been implemented with appropriate training. Mangar-elk, lifting apparatus has been allocated to each area and staff training is being implemented through 2016.

Level 2 multi-factorial falls risk screening is being carried out by some third sector organisations following training.

Community responders for non-injured falls are being implemented detail and coverage per locality is being mapped

Actions Identified to Address Current /Future Barriers
(Consideration should be given when describing barriers with regards to, how are the barriers going to be managed, who will take this work forward) The actions identified focused on preventative work in the community and this will take time to work through. The actions identified are well evidenced and should have an impact on meeting the target. A recently published economic evaluation provided an estimate of the cost to health and social care services in Scotland of managing the consequences of falls: in excess of £470 million (http://www.ncbi.nlm.nih.gov/pubmed/24215036) and without intervention is set to rise over the next decade as our population ages and the proportion with multi- morbidity and polypharmacy increases.
Additional Support Requirements Identified
Will be reviewed once training programme and initiatives outlined above have been completed and evaluated

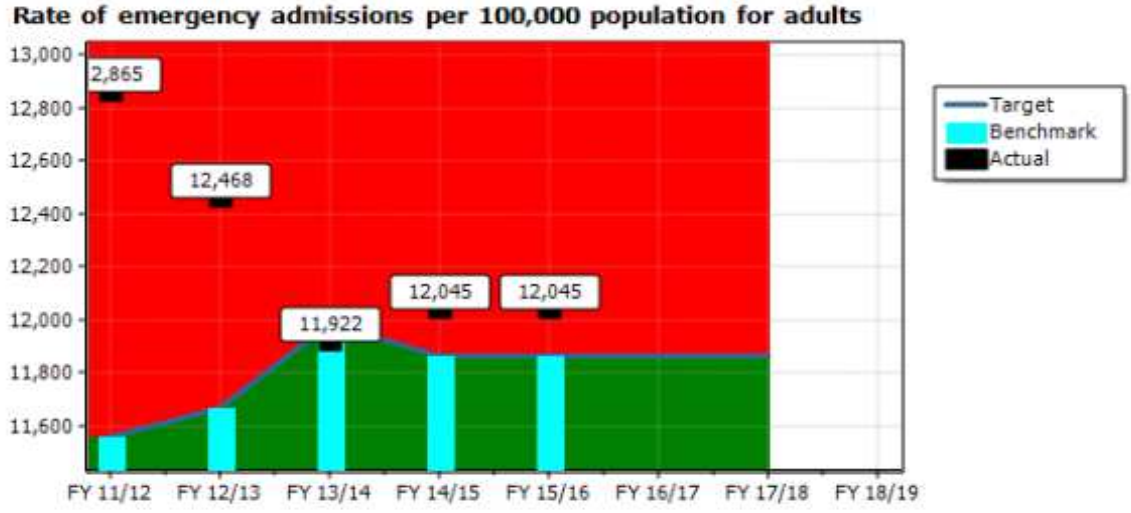
Improvement Forecast Date:	Review Date:
March 2016	On-going

Management Exception Reporting

Performance Indicator: Outcome 4 Rate of emergency admissions per 100,000 population for adults	Responsible Manager: Lorraine Paterson
Target: 11,865 Actual: 12,045	Date of Report: FQ2 16/17

Description of Exception

(Consideration should be given when describing the nature of the exception with regards to previous trends, reasons for exception, external /internal influences on performance, previous action taken to address performance, actions current in place to improve performance)



Rate of emergency admissions per 100,000 population for adults.

Published data: ISD Inpatient and Day Case Activity (2013/14)
Frequency: Financial Year, data available June each year.

Definition: Based on SMR01 returns for acute hospitals, and SMR04 data for psychiatric hospitals (note that some further work will be undertaken by ISD regarding this data source).
Linked to IJB Outcome 1,2,4,5 & 7.

Actions Identified to Address Exception and Improve Performance
(Consideration should be given when describing actions to address performance with regards what requires to be done, who is going to do it and how will this improve performance) The prevention of avoidable emergency admissions continues to be an area of focus for the localities. Applying the 6 essential actions for unscheduled care, including Anticipatory Care planning, community "pull through" and step up support his work. Community teams continue to have challenges with the provision of homecare, to fully facilitate these actions. Work with independent homecare providers and the commissioning team continues to support homecare provision. Performance information is being developed at locality level reflecting greater sensitivity for local performance
Actions Identified to Address Current /Future Barriers
(Consideration should be given when describing barriers with regards to, how are the barriers going to be managed, who will take this work forward)
Additional Support Requirements Identified

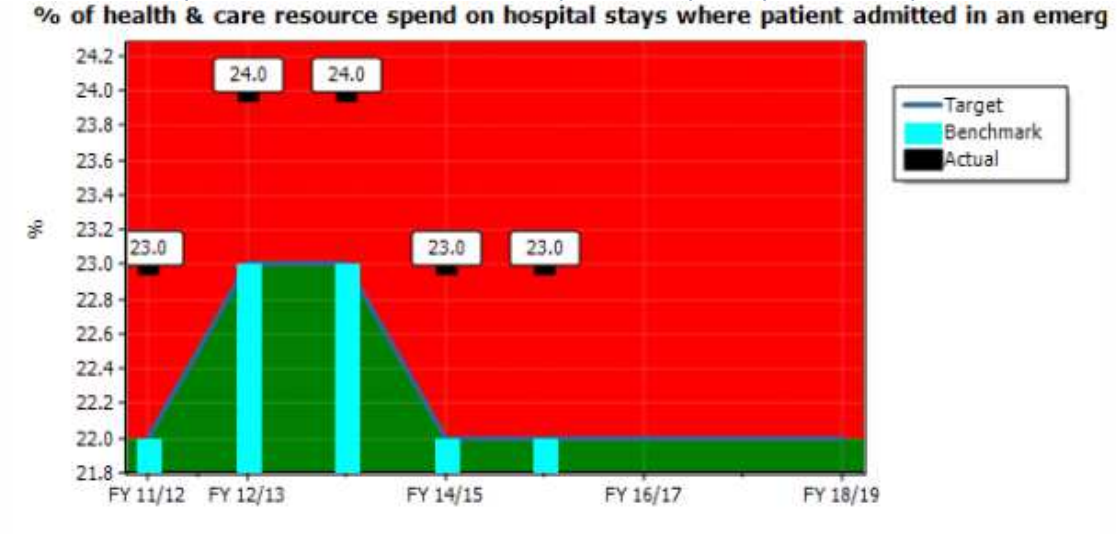
Improvement Forecast Date:	**Review Date:**

Management Exception Reporting

Performance Indicator: Outcome 4 % of health & care resource spend on hospital stays, patient admitted in an emergency	**Responsible Manager:** Allen Stevenson
Target: 22% Actual: 23%	Date of Report: FQ2 16/17

Description of Exception

(Consideration should be given when describing the nature of the exception with regards to previous trends, reasons for exception, external /internal influences on performance, previous action taken to address performance, actions current in place to improve performance)



Percentage of health and care resource spend on hospital stays where the patient admitted in an emergency.

Published data: ISD Standard Outputs - Health and Social Care Data Integration Frequency: Annual

Definition: Cost of emergency bed days for adults - Includes admissions from all hospital specialties, acute, geriatric long stay and mental health.

Actions Identified to Address Exception and Improve Performance

(Consideration should be given when describing actions to address performance with regards what requires to be done, who is going to do it and how will this improve performance)

Our HSCP staff are actively working to reduce emergency admissions to hospital across Argyll and Bute. Our community teams are attempting to intervene earlier when older people start to deteriorate at home and encounter problems with their physical or mental health.

Our approach to re-ablement is currently under review as we attempt to increase the impact of this work on sustaining people at home for longer and maximise their independent living skills. Re-ablement work increases confidence levels and people generally feel more able to undertake daily living tasks by themselves.

The early implementation of planning for discharge starts as soon as patients arrive

in hospital with target discharge dates identified shortly after admission. A recent example of this improvement work was highlighted as a result of an RPIW workshop in Oban where the team have been able to sustain lowering the number of days patients stay in hospital. Lessons learned from this activity need to be shared more effectively across all localities.

Actions Identified to Address Current /Future Barriers

(Consideration should be given when describing barriers with regards to, how are the barriers going to be managed, who will take this work forward)

- We need to ensure our re-ablement model is working effectively across all our community teams. We are currently planning a review of our progress across our community teams which will help deliver increased consistency of approach to re-ablement.
- We need to ensure we share and spread the good outcomes from a recent RPIW in Oban which has delivered shorter length of stay for the patients admitted to hospital.
- We need to accelerate work towards shifting the balance of care from hospital to community and ensure we achieve the current 80% target. This will only be achieved if we accelerate our re-design work across localities.

Additional Support Requirements Identified

The actions described above need to be secured to deliver our desired outcome of shifting the balance of care.

This is a medium term focusing on shifting the balance of care and hence seeing a corresponding shift in resources by disinvesting from acute and reinvesting in community services

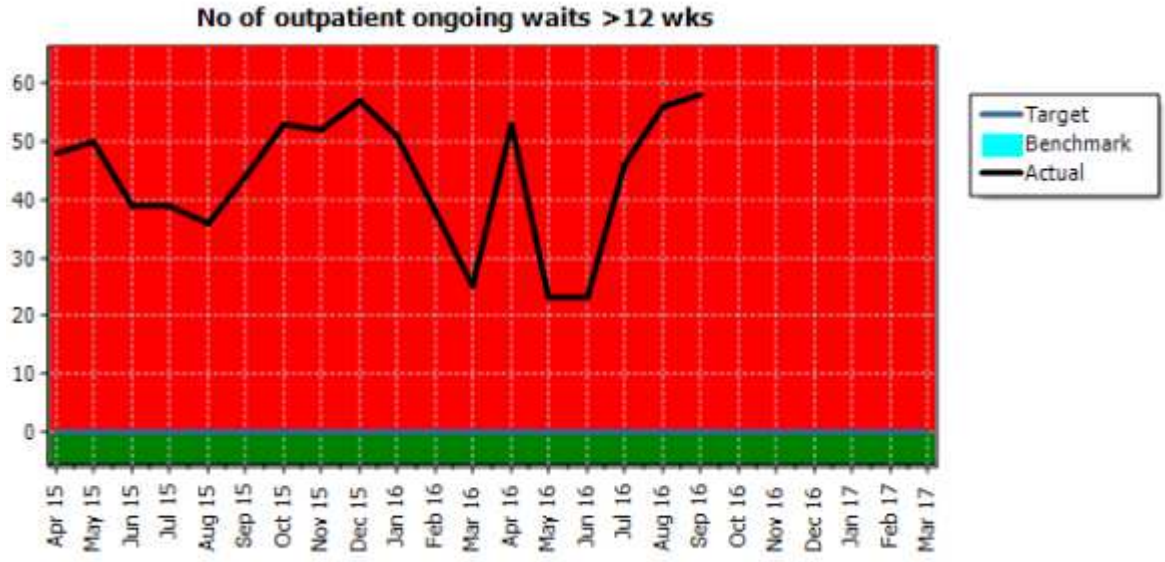
Improvement Forecast Date:	Review Date:
	Quarterly

Management Exception Reporting

Performance Indicator: Outcome 4 No of outpatient ongoing waits greater than12 wks	**Responsible Manager:** Lorraine Paterson
Target: 0 Actual: 58	Date of Report: FQ2 16/17

Description of Exception

(Consideration should be given when describing the nature of the exception with regards to previous trends, reasons for exception, external /internal influences on performance, previous action taken to address performance, actions current in place to improve performance)



Actions Identified to Address Exception and Improve Performance

(Consideration should be given when describing actions to address performance with regards what requires to be done, who is going to do it and how will this improve performance)

The table below details the breakdown of the waits in Argyll and Bute:

Hospital	Specialty	Number Waiting over 12 Weeks at end Sep16
Campbeltown Hospital	Dermatology	1
Campbeltown Hospital Total		1
Lorn and Islands Hospital	Chronic Pain Management Service	25

	Oral Surgery	16
	Dermatology	7
	Orthopaedics	4
	Gynaecology	1
	Haematology	1
	Ophthalmology	1
Lorn and Islands Hospital Total		55
Mull And Iona Community Hospital	Cardiology	1
	Ophthalmology	1
Mull And Iona Community Hospital Total		2
A&B HSCP Total		**58**

The most significant waits are in Pain, Oral Surgery and Dermatology at LIH.

There has been historical use of initiative clinics to reduce these waiting times, however these are expensive options and not affordable.

Actions Identified to Address Current /Future Barriers

(Consideration should be given when describing barriers with regards to, how are the barriers going to be managed, who will take this work forward)

There has been historical use of initiative clinics to reduce these waiting times, however these are expensive options and not affordable.

The most significant breach remains in the Pain Service delivered by the single consultant anaesthetist from LIH Oban. This is primarily due to the Consultant's capacity and the chronic nature of the pain patients requiring continual follow up thereby resulting in low number of patient discharges.

The HSCP has been working to look to maximise efficiencies within the service and have done the following:

- Redesigned the pathway by issuing patient questionnaires to get as much information from the patient to reduce appointment times
- Follow up the questionnaire with a telephone triage appointment to establish the best and most appropriate route for the patient to get treatment. This should reduce the amount of outpatient appointments required and will increase capacity.
- Physiotherapists participating in the pain service to triage, treat and manage appropriate patients which will allow the patients to be discharged from the Consultant caseload along with OT support.

- Self management tools for patients are being examined and rolled out to patients
- The waiting list administration for the service has been centralised to Oban Lorn and Islands hospital to ensure equity of appointing across the HSCP as waiting times differed depending on the availability of the Consultant to visit that area Oban, Kintyre and Mid Argyll).
- Utilising Technology Enabled Care (TEC) by using “Florence” a text reminder service to help patients self manage their pain control. There are 5 patients currently using Florence.
- Patients are being appointed in chronological order, ensuring the longest waiter is appointed first. Whilst there is still a long waiting list, the Service is stabilising and a significant reduction has been seen within the waiting time and breach numbers although this remains high.

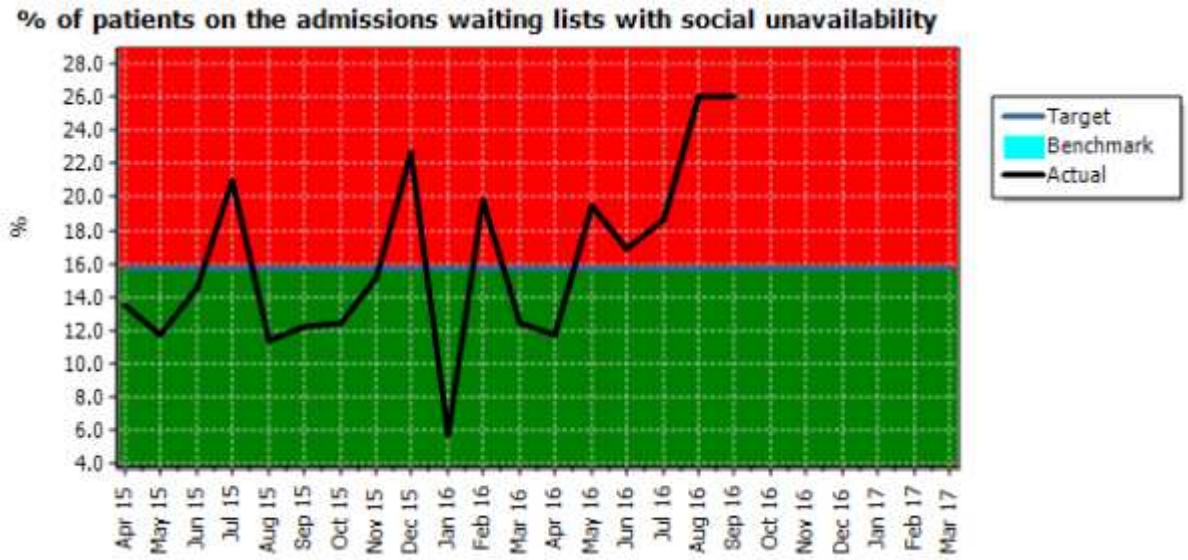
Additional Support Requirements Identified	
Solution is a combination of additional capacity and further redesign. However, sourcing an anaesthetic consultant with the relevant expertise for what is probably 1 or 2 extra sessions a month is unlikely and expensive if waiting list initiative rates are used.	
Improvement Forecast Date:	**Review Date:**
Not in the next 6 months	On-going

Management Exception Reporting

Performance Indicator: Outcome 4 % of patients on the admissions waiting lists with social unavailability	**Responsible Manager:** Lorraine Paterson
Target: 15.7% Actual: 26%	Date of Report: FQ2 16/17

Description of Exception

(Consideration should be given when describing the nature of the exception with regards to previous trends, reasons for exception, external /internal influences on performance, previous action taken to address performance, actions current in place to improve performance)



This target relates to day case and inpatient admissions at Lorn and Island hospital Oban (primarily general surgery). The patient focused booking system allows patients to revise their appointments and in some cases defer admission due to personal circumstances and this is coded as social unavailability, due to patient personal choice.

Actions Identified to Address Exception and Improve Performance

(Consideration should be given when describing actions to address performance with regards what requires to be done, who is going to do it and how will this improve performance)

The local team have been alerted to the increasing trend since May and an investigation into the increase is underway. It should be noted that LIH admission and day case waiting time is less than 7 weeks as at 4th November 2016.

Actions Identified to Address Current /Future Barriers

(Consideration should be given when describing barriers with regards to, how are the barriers going to be managed, who will take this work forward)

Additional Support Requirements Identified

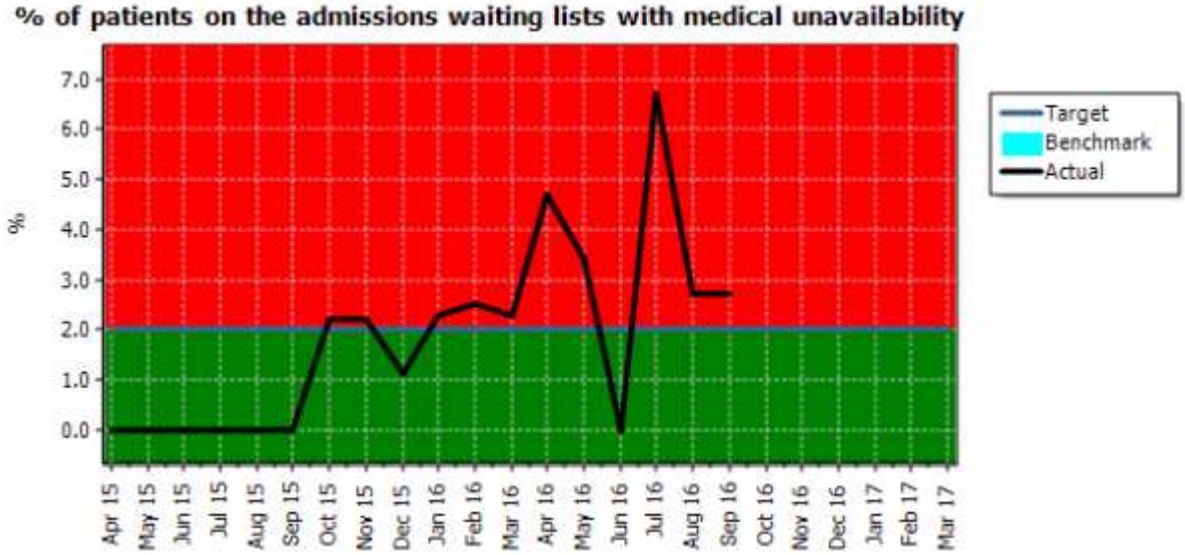
Improvement Forecast Date:	Review Date:
March 2017	Monthly

Management Exception Reporting

Performance Indicator: Outcome 4 % of patients on the admissions waiting lists with medical unavailability	**Responsible Manager:** Lorraine Paterson
Target: 2% Actual: 2.7%	Date of Report: FQ2 16/17

Description of Exception

(Consideration should be given when describing the nature of the exception with regards to previous trends, reasons for exception, external /internal influences on performance, previous action taken to address performance, actions current in place to improve performance)



Actions Identified to Address Exception and Improve Performance

(Consideration should be given when describing actions to address performance with regards what requires to be done, who is going to do it and how will this improve performance)

This is solely dependent on a clinical decision, usually made at pre-assessment, if people are too unwell to be admitted.

Actions Identified to Address Current /Future Barriers

(Consideration should be given when describing barriers with regards to, how are the barriers going to be managed, who will take this work forward)

Additional Support Requirements Identified

Improvement Forecast Date:	Review Date:

Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Agenda item: 5.6i

Date of Meeting : **30 November 2016**

Title of Report : **Budget Monitoring – October 2016**

Presented by : **Caroline Whyte, Chief Financial Officer**

The Integration Joint Board is asked to :

- **Note** the overall Integrated Budget Monitoring report for the October 2016 period, including:
  - Integrated Budget Monitoring Summary
  - Quality and Financial Plan Progress
  - Financial Recovery Plan
  - Financial Risks
  - Reserves
  - Other Project Funding
- **Note** that as at the October period there is a projected year-end overspend of £1.2m primarily in relation to the deliverability of the Quality and Financial Plan, the cost of medial locums and increased demand for social care services.
- **Note** the progress with the delivery of the Quality and Financial Plan and the forecast shortfall in delivery of savings, and consider the approach to reviewing these as part of the budget planning process for 2017-18.
- **Agree** that the previously approved financial recovery plan requires to continue to be implemented to ensure the delivery of a balanced integrated budget for the 2016-17 financial year, and that the focus should be on achieving recurring savings.

1. EXECUTIVE SUMMARY

1.1 The main summary points from the report are noted below:

- Robust budget monitoring processes are key to ensure that the expenditure incurred by the IJB partners is contained within the approved budget for 2016-17 and that overall the partnership delivers a balanced year-end outturn position.
- This report provides information on the financial position of the Integrated Budget as at the end of October 2016. The projected year-end outturn position is an overspend of £1.2m, the Integration Joint Board requires assurance that this position can be brought back into line with the available budget by the financial year-end. A financial recovery plan was approved by the IJB on 4

August to address the then forecast £1.5m year-end overspend, this position has reduced by £0.3m. Progress was being made with the projected outturn position and as at the September period the forecast outturn position was reduced to £0.2m. This position has deteriorated due to updated estimates of savings to be delivered in 2016-17, particularly in relation to savings to be delivered from Social Work services.

- There are significant financial risks in terms of service delivery for 2016-17 and there are mitigating actions in place to reduce or minimise these, these risks should continue to be closely monitored together with the delivery of the Quality and Financial Plan and financial recovery plan.

2. INTRODUCTION

2.1 This report sets out the financial position for Integrated Services as at the end of October 2016. Budget information from both Council and Health partners has been consolidated into an Integrated Budget report for the SMT.

3. DETAIL OF REPORT

3.1 INTEGRATED BUDGET MONITORING SUMMARY

3.1.1 This main overall financial statement is included as Appendix 1. This contains an objective (service area) financial summary integrating both Health and Council services, with a reconciliation of the overall split of the budget allocation.

Year to Date Position – YTD Underspend - £1.327m

3.1.2 The main areas to note from this are:

- The overall Year to Date variance is an underspend of £1.327m. This consists of an underspend of £1.378m in Council delivered services and an overspend of £0.051m in Health delivered services.
- Within Health provided services the overspend is mainly in relation to the budget profile of savings for 2016-17 which have not yet been implemented and additional costs in relation to locums, the year to date position is in line with the forecast outturn position noted below.
- Within Council provided services the year to date underspend is mainly in relation to delays in receipt and processing of supplier payments. This year to date underspend position is not necessarily an indication of the likely year-end outturn position.

3.1.3 Although there is a year to date underspend of £1.378m this should not be relied upon as an indication of the likely year-end outturn position. Council and Health partners use different financial systems and treatments for the monthly profiling of budgets and recording of actual costs which results in financial information relating to the year to date position for the integrated budget not being a reliable indicator of the year-end position.

Forecast Outturn Position – Projected Overspend - £1.240m

3.1.4 The year-end forecast outturn position for the October period is a projected overspend of £1.240m. The main areas are noted below:

- Adult Care – projected overspend £4.8m:
  - Anticipated shortfall of £3.5m in the delivery of savings as part of the Quality and Financial Plan, further detail is included in section 3.2. There has been around £1m added to the forecast overspend for Adult Care in October alone due to a re-assessment of the deliverability of the savings.
  - Budget overspends in relation to locum cover for vacancies and sickness absence
  - Projected overspends for additional demand for services including care home placements, supported living and joint residential budgets, due to new clients and the increasing needs of existing clients. Options are being worked on to deliver cost reductions for Supported Living services which are expected to take effect from early December 2016.

- Chief Officer – projected underspend £0.7m
  - Projected underspend in relation to the additional funding of £0.715m set aside for the investment in Community Based Care and the requirements of continuing care. These funds require to remain uncommitted to ensure the delivery of a balanced year-end budget position.

- Children and Families – projected underspend £0.5m:
  - Underspend of £0.3m in relation to vacancy savings in Health posts.
  - Projected underspends in relation to children's houses due to reduced dependency of children placed in the units and lower levels of occupancy and in supporting young people leaving care due to the delay in the development of a new multi-disciplinary team to support young people leaving care.
  - These are partly offset by projected overspends in children and families area teams due to agency staff, the criminal justice partnership share of the partnership shortfall and in residential placements where an increase in costs has resulted in a forecast underspend changing to be an overspend position. This reflects the demand led nature of the service and the high cost of some care packages.

- Budget Reserves – projected underspend £1.8m – represents the uncommitted element of budget reserves which can be utilised to offset the overall projected outturn position. This projected outturn position is based on an assessment of the likely outturn informed by financial performance in previous years. These are non-recurring underspends and in some cases the funding will require to be re-instated for 2017-18.

3.1.5 The forecast outturn position is reliant on a number of assumptions around the current and expected level of service demand and costs, this is subject to change and is reported through routine monthly monitoring. Although there is an overall overspend of £1.240m currently projected this only represents 0.9% of the annual budget, therefore there remain opportunities before the end of the financial year to bring this position back into line.

3.1.6 There is an overall increase in funding of £1.316m compared to the approved budget. There is an increase in available funding from £256.001m to £257.491m, these in-year changes in funding are also noted in Appendix 1. This relates to an overall increase in Health Funding, mainly relating to allocations of funding from the Scottish Government partly offset by a transfer to NHS Highland for centrally provided services. There is an overall increase in Council funding reflecting the amounts drawn down from reserve balances, partly offset by budget transferred out with Integration Services.

3.2 QUALITY AND FINANCIAL PLAN PROGRESS

3.2.1 There is a significant risk around the deliverability of the Quality and Financial Plan for 2016-17. There are significant budget savings to be delivered within an accelerated timescale and it is absolutely key that these remedial plans are delivered to produce a sustainable balanced budget for the partnership. The Integration Joint Board previously requested further detail on the progress with delivering savings, including the impact on the 2017-18 budget.

3.2.2 Progress with the individual budget reductions outlined in the Quality and Financial Plan is detailed in Appendix 2. This notes the savings delivered to date, an overall risk assessment of the deliverability of the individual savings, and an estimate of the amount to be delivered during 2016-17 and 2017-18. The risk category of the individual savings has been updated and this can be compared with the anticipated risk of delivery when the savings were approved in June 2016.

3.2.3 There are budget reductions totalling £8.498m required to produce a balanced partnership budget. These savings have all been previously approved by the Integration Joint Board for implementation.

3.2.4 Progress on the delivery of savings is summarised below:

Risk Category	Number	Budget Reduction £000	Achieved to October 2016 £000	Remaining £000	Forecast Shortfall 2016-17 £000	Forecast Shortfall 2017-18 £000
RED	20	3,625	645	2,980	2,666	1,545
AMBER	19	2,538	891	1,647	878	111
GREEN	24	2,335	1,887	448	0	0
TOTAL	**63**	**8,498**	**3,423**	**5,075**	**3,544**	**1,656**

3.2.5 As at the end of October 2016 recurring budget reductions of £3.423m have been achieved, this compares to a total of £3.209m at the September 2016 period, an increase of £0.214m. This demonstrates the progress in delivering savings.

3.2.6 Additional savings in social care services were approved by the Integration Joint Board on 22 June 2016. Plans to deliver these savings are in place however it is unlikely these will all be fully delivered in 2016-17 given the timescales around engagement and there are likely to be delays with releasing some of the savings. Progress with delivery of these savings has been reviewed and an update on the social care service savings is included within the overall savings monitoring in Appendix 2. The forecast shortfall in 2016-17 for all savings at the September monitoring period was £2.808m and this has increased to £3.544m, this is primarily in relation to the delivery of the social care service savings.

3.2.7 The update on progress includes an estimate of the recurring shortfall in delivery of savings on a recurring basis from 2017-18 onwards, this estimated total shortfall is £1.656m and this will be factored into the budget projections for 2017-18. The removal of these previously approved savings from the Quality and Financial Plan from 2017-18 onwards will require approval from the Integration Joint Board. The IJB should consider requesting further information from services to challenge the deliverability of savings to ensure an informed decision can be taken before removing these from the savings plan. An approach to this should be considered as part of the budget process for 2017-18.

3.2.8 The risk category attached to each of the savings is an assessment of the deliverability. The risk categories have been updated for the October period. There were originally eight options assessed to be red risk which accounted for £2.250m of the total savings. With the risk category reviewed there are now 20 options classed as red risk and these account for £3.625m of the total savings. This is indicative of the challenges and complexity with delivering service changes which were not foreseen when they were approved. The updated red risk savings are noted below:

- Prescribing
- Rural Cowal Out of Hours Service
- Re-design of community pathways and community hospital services to shift the balance of care as a result of reduced length of stay, reduced delayed discharges and reduced emergency admissions – Cowal, Bute, Kintyre and Islay
- Closure of AROS
- Kintyre Medical Group
- Management and Corporate Staffing
- IT and Telephony Re-provision
- Ardlui Respite Facility
- Consultation Support Forum
- Homecare Review
- Struan Lodge Service Re-design
- Thomson Court Day Service
- Bowman Court Progressive Care Centre
- Mental Health Support Team
- Support for Carers
- Learning Disability Day Services
- Homecare Packages

3.2.9 There is a reported forecast overspend of £1.240m as at the October 2016 period, this is primarily in relation to the expected shortfall in the delivery of the Quality and Financial Plan. The estimate is that £3.544m of the savings will not be deliverable in 2016-17, services are working to address this position and underspends in other service areas have been forecast to reduce this expected year-end overspend position.

3.3 FINANCIAL RECOVERY PLAN

3.3.1 The Integration Joint Board has a responsibility to ensure a balanced year-end budget position and there will be financial consequences for the partner bodies and the IJB if this not delivered. Therefore a recovery plan was approved by the IJB on 4 August to address the reported forecast overspend of £1.5m as at the June period.

3.3.2 The plan included management actions to bring the projected spend back into line with budget. The actions do not have any policy implications, will have limited impact on the day to day delivery of services and can be delivered in the normal course of business. The areas identified included:

- Review of the payment to Greater Glasgow and Clyde – initial analysis of the most recent iteration of the financial model indicates that the saving in relation to this included in the Quality and Financial Plan is achievable. There may be a further opportunity to reduce the payment by negotiation.
- Review spending plans against non-recurring funding allocations with a view to removing uncommitted elements of any non-recurring resource allocations. Depending on the nature of the funding there be a requirement to re-instate funding in 2017-18.
- Further efficiencies and cost reduction through vacancy management, management of sickness absence and standardisation of procurement processes.
- Drive forward the re-design of community pathways and community hospital services to shift the balance of care as a result of reduced length of stay, reduced delayed discharges and reduced emergency admissions.
- Review of future commitments on non-pay non-essential expenditure budgets, for example furniture replacement.
- Restricting new investment to core service delivery.

3.3.3 The Strategic Management Team has been adhering to this recovery plan, the forecast overspend position has reduced from £1.5m in June to £1.2m as at the October financial monitoring period. The plan has recovered more than £0.3m of the projected position as the projected outturn at September was an overspend of £0.2m. The increase in the estimated non-delivery of savings in the October period has increased the projected overspend position again.

3.3.4 The Strategic Management Team are clear that the focus should be directed to actions that will deliver recurring savings, the main area being the driving forward the delivery of the Quality and Financial Plan. Any other actions will assist in producing an overall balanced year-end position for 2016-17 but will lead to a greater budget gap to address on a recurring basis from 2017-18. The delivery of the recovery plan to date is mainly in relation to one-off actions that will not address the budget gap on a recurring basis. For example the removal of budget reserves, the non-committal of project funding and the additional budget allocations for community based care and continuing care. Some of

these budgets will not be available in 2017-18 and in some cases by utilising these funds in this way this will add to the pressures for 2017-18 as the funding will require to be re-instated. The focus should be directed to actions that will deliver recurring savings, the main area being driving forward the Quality and Financial Plan.

3.4 FINANCIAL RISKS

3.4.1 An assessment of financial risks together with the likelihood and impact and the potential financial consequences for the Integrated Budget is included as Appendix 3. This only includes financial related risks and highlights areas where there are potential cost or demand pressures facing service delivery.

3.4.2 There are 13 financial risks with a potential financial impact of £4.0m noted at the October 2016 period. These are assessed in terms of likelihood and a summary of the risks is noted in the table below:

Likelihood	Number	Potential Financial Impact £000
Almost Certain	0	0
Likely	3	950
Possible	5	1,750
Unlikely	5	1,300
TOTAL	**13**	**4,000**

3.4.3 The potential financial impact represents the estimated full year impact on the budget, this value will reduce as we progress through the financial year. The financial risks have reduced throughout the year, mainly as a result of the risks materialising and being reported through the forecast outturn position, for example the risk of non-delivery of savings in the Quality and Financial Plan.

3.5 RESERVES

3.5.1 The Integration Joint Board does not have any opening reserve balances but there are inherited reserve balances from Council delivered services. These balances for 2016-17 total £0.4m. The balances are mainly in relation to unspent grant monies carried forward or funds the Council has earmarked from the general fund for service development. The funds are committed for specific projects previously approved by the Council, this includes funding for:

- Self Directed Support
- Sensory Impairment
- Autism Strategy
- Care at Home – Fairer Work Practices
- Integrated Care Fund
- Early Intervention (Early Years Change Fund)
- Criminal Justice Transformation

3.6 OTHER PROJECT FUNDING

3.6.1 There are specific additional funding allocations to drive forward integration work including the Integrated Care Fund, Technology Enabled Care and Delayed Discharge. An Improving Care Programme Board has been put into place in terms of the governance arrangements for these funds and their role is to ensure that funds are directed to achieve the desired priorities.

3.6.2 These funds are time-limited and it is crucial they are used effectively to invest in the changes in service delivery required to deliver on the outcomes in the Strategic Plan. The funding available for 2016-17 totals £3.365m and Appendix 4 notes the allocations from these funds.

4. CONTRIBUTION TO STRATEGIC PRIORITIES

4.1 The Integration Joint Board has a responsibility to set a budget which is aligned to the delivery of the Strategic Plan and to ensure the financial decisions are in line with priorities and promote quality service delivery, monitoring this budget through the financial year is key to ensuing a balanced budget position.

5. GOVERNANCE IMPLICATIONS

5.1 Financial Impact

5.1.1 The monitoring of the budget is key to ensure the delivery of the financial plans for 2016-17, as at the October 2016 monitoring period significant financial risks have been identified and services are forecasting a year-end overspend of £1.2m. The recovery plan requires to continue to be implemented and monitored to ensure this can be brought back into line with the delegated budget.

5.2 Staff Governance

None

5.3 Clinical Governance

None

6. EQUALITY & DIVERSITY IMPLICATIONS

None

7. RISK ASSESSMENT

7.1 Financial risks are monitored as part of the budget monitoring process.

8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

8.1 Where required as part of the delivery of the quality and financial plan local stakeholder and community engagement will carried out as appropriate in line with the re-design of service provision.

9. CONCLUSIONS

9.1 This report summarises the financial position of the Integrated Budget as at October 2016. The forecast year-end outturn position is a projected overspend of £1.2m, the previously approved financial recovery plan requires to continue to be implemented and monitored to ensure the delivery of a year-end balanced budget. The focus should be placed on the delivery of the savings from the Quality and Financial Plan to reduce expenditure on a recurring basis.

9.2 The forecast overspend position has decreased from the June period by £0.3m as a result of progress with the recovery plan and further one-off income or budget reductions which can be utilised to balance the overall budget position in 2016-17. These actions have however been partly offset by additional demand pressures and a forecast shortfall in the delivery of savings previously approved from social care services.

9.3 The report also highlights the level of financial risk associated with delivering a year-end balanced Integrated Budget, there are significant financial risks in relation to the demands on service delivery and significant risks in relation to the delivery of the Quality and Financial Plan. These risks and the projected outturn position will continue to be closely monitored and reported as part of the overall approach to budget monitoring.

APPENDICES:

Appendix 1 – Integrated Budget Monitoring Summary – October 2016
Appendix 2 – Quality and Financial Plan Progress – October 2016
Appendix 3 – Financial Risks – October 2016
Appendix 4 – Other Project Funding – October 2016

INTEGRATED BUDGET MONITORING SUMMARY - OCTOBER 2016

	Year to Date Position				Forecast Outturn			Previous Period	
	YTD Actual £000	YTD Budget £000	YTD Variance £000	Variance %	Annual Budget £000	Forecast Outturn £000	Forecast Variance £000	Forecast Variance £000	Movement in month £000
Service Delegated Budgets:									
Adult Care	71,277	70,984	(293)	-0.4%	126,311	131,163	(4,852)	(3,822)	(1,030)
Alcohol and Drugs Partnership	665	694	29	4.2%	1,334	1,284	50	50	0
Chief Officer	362	286	(76)	-26.6%	1,448	746	702	706	(4)
Children and Families	10,697	11,090	393	3.5%	20,128	19,618	510	674	(164)
Community and Dental Services	2,392	2,396	4	0.2%	4,108	4,108	0	0	0
Integrated Care Fund	577	699	122	17.5%	2,090	1,864	226	217	9
Lead Nurse	753	789	36	4.6%	1,348	1,298	50	30	20
Public Health	718	744	26	3.5%	1,264	1,234	30	0	30
Strategic Planning and Performance	2,058	2,113	55	2.6%	3,329	3,268	61	27	34
	89,499	89,795	296	0.3%	161,360	164,583	(3,223)	(2,118)	(1,105)
Centrally Held Budgets:									
Budget Reserves	0	800	800	100.0%	2,295	495	1,800	1,800	0
Depreciation	1,516	1,522	6	0.4%	2,649	2,636	13	17	(4)
General Medical Services	8,824	8,777	(47)	-0.5%	15,344	15,344	0	(20)	20
Greater Glasgow & Clyde Commissioned Services	33,981	33,900	(81)	-0.2%	58,116	58,316	(200)	(158)	(42)
Income - Commissioning and Central	(784)	(743)	41	-5.5%	(1,181)	(1,221)	40	0	40
Management and Corporate Services	760	906	146	16.1%	1,806	1,626	180	137	43
NCL Primary Care Services	5,223	5,223	0	0.0%	8,350	8,350	0	0	0
Other Commissioned Services	2,084	2,250	166	7.4%	3,855	3,705	150	100	50
Resource Release	2,856	2,856	0	0.0%	4,897	4,897	0	0	0
	54,460	55,491	1,031	1.9%	96,131	94,148	1,983	1,876	107
Grand Total	**143,959**	**145,286**	**1,327**	**0.9%**	**257,491**	**258,731**	**(1,240)**	**(242)**	**(998)**

Reconciliaton to Council and Health Partner Budget Allocations:

	Year to Date Position				Forecast Outturn			Previous Period	
	YTD Actual £000	YTD Budget £000	YTD Variance £000	Variance %	Annual Budget £000	Forecast Outturn £000	Forecast Variance £000	Forecast Variance £000	Movement in month £000
Argyll and Bute Council	30,150	31,528	1,378	4.4%	55,727	56,967	(1,240)	8	(1,248)
NHS Highland	113,809	113,758	(51)	0.0%	201,764	201,764	0	(250)	250
Grand Total	**143,959**	**145,286**	**1,327**	**0.9%**	**257,491**	**258,731**	**(1,240)**	**(242)**	**(998)**

INTEGRATION JOINT BOARD

APPENDIX 1

FUNDING RECONCILIATION - OCTOBER 2016

Partner	£000	£000	£000
Argyll and Bute Council:			
Opening Funding Approved		55,553	
Annual Budget at October 2016		55,727	
Movement		**174**	
Details:			
Non-recurring drawdown of budget from Reserves			236
Reduction due to re-alignment of Utility Budgets across the Council			(54)
Transfer of Budget outwith Integration for Helensburgh Office receptionist			(8)
			174
NHS Highland:			
Opening Funding Approved:			
Core NHS Funding	195,868		
Additional SG Funding	4,580		
Opening Funding Approved		200,448	
Annual Budget at October 2016		201,764	
Movement		**1,316**	
Details:			
Budget Carry Forwards (ICT, TEC & ADP)			716
New Medicines Funding			1,000
Other SG funding increases/decreases			1,672
Transfer to Health Board for Central Services			(2,072)
			1,316

INTEGRATION JOINT BOARD **APPENDIX 2**

QUALITY AND FINANCIAL PLAN PROGRESS - OCTOBER 2016

				TARGET 2016-17		Achieved October 2016	Remaining						
New Ref	Service Area	Description	Lead	Budget Reduction £000	FTE Reduction	£000	£000	Progress	ORIGINAL Risk of Delivery (RAG)	CURRENT Risk of Delivery (RAG)	Projected Shortfall 2016-17	Projected Shortfall 2017-18 onwards.
1	Prescribing	Targeted focus on safe, effective, appropriate cost effective prescribing, as well as reducing waste. Argyll and Bute Medicines Management Group re-established to take forward actions.	Fiona Thomson	500	0.0	239	261	High risk area in terms of delivery of savings as there have been failures in the past in delivering savings in prescribing. 48% of saving achieved to October, including use of scriptswitch, dose optimisation, change to generics, patient access scheme rebates, primary care rebate scheme and formulation changes. It is expected that this saving may be achieved in full in 2017-18, however new costs for prescribing continue to create pressures on the overall prescribing budget.	RED	RED	220	0
2	NHS GG&C Service Level Agreement	Participate in a review of the costing and activity model to review tariff and activity levels. Take action to reduce admission rates and speed discharge up to local services and reduce outpatient follow up appointments.	Stephen Whiston	500	0.0	500	0	Full saving achieved through impact of the West of Scotland Cross Boundary Flow in terms of the fluctuations in patient activity.	AMBER	GREEN	0	0
3	Commissioned Services	Review individual placements out of the area and where possible re-negotiate tariffs/contracts.	Stephen Whiston	250	0.0	250	0	Achieved.	GREEN	GREEN	0	0
4	Speech & Language Therapy Services	Re-align services to focus on delivering capacity building and a universal approach in partnership with Education.	Linda Currie	140	3.2	125	15	On track to be fully delivered.	GREEN	GREEN	0	0
5	Rural Cowal Out of Hours Service	Carry out review of service delivery model and implement service re-design.	Allen Stevenson	300	2.9	0	300	No evidence of progress being made to release savings. Service should be provided from Dunoon but would require the co-operation of GPs, delivery of the saving is not fully within the control of the service.	RED	RED	300	300
6	Re-design Community Hospital - Cowal	Re-design provision of services across the Argyll and Bute area, with a focus on quality outcomes and aligning service provision to capacity and current service delivery requirements. By shifting the balance of care as a result of reduced length of stay, reduced Delayed Discharges and reduced energy admissions.	Allen Stevenson	500	6.7	0	500	A review of in-patient services has concluded that it is possible to reduct the number of beds in Cowal Community Hospital by 6 from 20 to 14, achieving a recurring saving on nurse staff costs of £137k. A proposal is being presented to the LPG for agreement prior to implementation. Bed numbers would require to reduce further to deliver the full saving. No saving has been declared to date for 2016-17 but there are underspends in nursing staff costs.	RED	RED	363	0
7	Re-design Community Hospital - Victoria Hospital, Bute		Allen Stevenson	250	4.1	0	250	The current plan is to reduce the number of beds in Rothesay Victoria Hospital by 5 from 13 to 8. This could achieve a recurring saving of £33k in nursing staff costs. However no commitment has been provided by the locality to achieve any saving and to date the budget is overspent.	RED	RED	250	250
8	Re-design - Lorn and Islands Hospital		Lorraine Paterson	500	11.5	151	349	The current plan is to re-design the medical unit reducing the bed compliment from 42 to 34, a reduction of 8. This will achieve savings of £288k on nursing pay costs, savings declared to date for 2016-17 relate to reductions in one ward.	AMBER	AMBER	212	0
9	Re-design Community Hospital - Mid Argyll		Lorraine Paterson	500	22.0	300	200	This target relates to savings on nurse staff costs from a reduction of 17 beds in the lower ground floor dementia ward. This savings should be achieveable in the longer term as the delay in implementation for 2016-17 is due to low staff turnover.	GREEN	AMBER	180	0

QUALITY AND FINANCIAL PLAN PROGRESS - OCTOBER 2016

				TARGET 2016-17		Achieved October 2016	Remaining					
New Ref	Service Area	Description	Lead	Budget Reduction £000	FTE Reduction	£000	£000	Progress	ORIGINAL Risk of Delivery (RAG)	CURRENT Risk of Delivery (RAG)	Projected Shortfall 2016-17	Projected Shortfall 2017-18 onwards.
10	Re-design Community Hospital - Kintyre	Re-design provision of services across the Argyll and Bute area, with a focus on quality outcomes and aligning service provision to capacity and current service delivery requirements. By shifting the balance of care as a result of reduced length of stay, reduced Delayed Discharges and reduced energy admissions.	Lorraine Paterson	250	3.8	18	232	The initial plan was to reduce by 4 beds, this has now been changed to reduce staffing levels while maintaining the existing bed complement. To deliver additional savings in 2017-18 there would need to be a willingness and a plan to reduce bed numbers and the staffing levels further.	RED	RED	162	0
11	Re-design Community Hospital - Islay		Lorraine Paterson	250	5.5	20	230	A review of nurse staffing has produced a small saving, it is difficult to see how further savings can be achieved while an in-patient facility remains open. Staffing levels are now 3 per shift and there is no support to reduce this any further.	RED	RED	230	230
12	Argyll and Bute Hospital Staffing	Transfer of inpatient mental health services from Argyll and Bute Hospital to MACHICC.	Lorraine Paterson	300	8.4	122	178	On track to be fully delivered.	GREEN	GREEN	0	0
13	Closure of West House	A number of support services for Argyll and Bute Hospital are provided from this building, staff would be relocated to other available accommodation.	David Ross	500	0.0	131	369	In progress. Full saving will not be realised until building fully closes. Much work has still to be done to re-locate staff and services from West House and Succoth.	AMBER	AMBER	0	0
14	Closure of AROS	A number of support services including HR and Finance are provided from this building, staff would be relocated to other available accommodation.	David Ross	150	0.0	0	150	High risk as substantial amount of work remaining to arrange re-location of staff and services from the building. Unlikely that any saving will be achieved in 2016-17. Work to re-locate staff will have to be pushed forward to ensure the full saving can be achieved in 2017-18.	RED	RED	150	0
15	Kintyre Medical Group	In the longer term it is anticipated that the operation of the services will be taken on by Campbeltown Medical Practice, a transitional plan is in development to support this change.	Lorraine Paterson	75	2.0	0	75	No saving achieved to date. No certainty over delivering this service and the costs associated with the service transferring.	GREEN	RED	50	50
16	Management & Corporate Staffing	Level of staffing review, reduced with no or limited impact on service delivery.	George Morrison	200	5.0	14	186	No progress to date as all vacancies are being filled, saving achieved to date in relation to PVG checks. Unlikely that further savings will be delivered from a general non-specific corporate savings target as services all want to maintain staffing levels. If savings do not come forward for 2017-18 more detailed corproate savings plans should be included in the quality and financial plan.	AMBER	RED	150	100
17-20	Locality General Savings 1%	Efficiency savings target applied across localities.	Allen Stevenson/ Lorraine Paterson/ Louise Long	602	0.0	277	325	In progress. Savings expected to be fully delivered in OLI locality the remaining areas all forecasting a shortfall. Plans should be reviewed by localities to ensure recurring savings are removed from the 2016-17 to ensure no issue for the 2017-18 budget.	AMBER	AMBER	137	0
21	Review Day Hospital Services for Older People with Dementia	Re-design of traditional day services.	Lorraine Paterson	25		0	25	No savings achieved as yet, dependant on the closure of the day hospital service in Campbeltown.	AMBER	AMBER	0	0

INTEGRATION JOINT BOARD **APPENDIX 2**

QUALITY AND FINANCIAL PLAN PROGRESS - OCTOBER 2016

				TARGET 2016-17		Achieved October 2016	Remaining						
New Ref	Service Area	Description	Lead	Budget Reduction £000	FTE Reduction	£000	£000	Progress	ORIGINAL Risk of Delivery (RAG)	CURRENT Risk of Delivery (RAG)	Projected Shortfall 2016-17	Projected Shortfall 2017-18 onwards.
22	IT Services	Productivity gains and telephony cost reduction.	Stephen Whiston	50	0.0	0	50	Business case being developed for longer term savings in telephones and IT, unlikely that any savings will be delivered this financial year. The investment required to extend the Lync system across the HSCP is significant and could also deliver significant savings. Recommended that this saving is removed from the plan and replaced with savings in line with the business case when this has been developed.	RED	RED	50	50
23	AHP Service Redesign Helensburgh for Dietetics and Podiatry	Identify opportunities and deliver re-design within the community mental health team.	Allen Stevenson	42	0.0	0	42	Unlikely to fully achieve target, specifically in relation to Dietetics.	AMBER	AMBER	27	27
24	CMHT Nursing Redesign Helensburgh		Allen Stevenson	11		11	0	Achieved.	GREEN	GREEN	0	0
25	Islay - Reduction in Patient Travel	Investigate and where possible provide appropriate services locally to reduce travel.	Lorraine Paterson	30		30	0	Achieved.	GREEN	GREEN	0	0
26	Public Health Services Redesign		Elaine Garman	35		35	0	Achieved.	GREEN	GREEN	0	0
27	Kintyre Patient Transport Redesign	Investigate and where possible provide appropriate services locally to reduce travel.	Lorraine Paterson	25		0	25	No evidence of progress to date and no plans in place to re-design the service. Savings would require reducing air travel and the number of patient escorts.	AMBER	AMBER	25	25
28	Mid Argyll/A&B Hospital Catering Services	Relocation and Conversion to Cook/Freeze	Lorraine Paterson	50		50	0	Achieved.	GREEN	GREEN	0	0
29	Mid Argyll Operational Teams Redesign	Re-design and restructure community teams to deliver single system approach to care delivery	Lorraine Paterson	20		0	20	In progress.	AMBER	AMBER	0	0
30	Child Health	Review of child health medical staffing levels.	Louise Long	10		10	0	Achieved.	GREEN	GREEN	0	0
31	Learning Disabilities	Review the provision of day services considering external provision.	Lorraine Paterson	25		0	25	In progress, not expected to be delivered in 2016-17.	AMBER	AMBER	25	0
32	Clinical Governance	Review of clinical governance team workload and staffing.	Liz Higgins	20		0	20	In progress, not expected to be delivered in 2016-17.	AMBER	AMBER	20	0
33	Infection Control	Review of infection control team workload and staffing.	Liz Higgins	10		10	0	Achieved.	AMBER	AMBER	0	0
34	Child Protection Services	Review of child protection services budget.	Liz Higgins	20		20	0	Achieved.	GREEN	GREEN	0	0
35	Medical Physics	Review provision of medical physics services to Argyll and Bute.	Lorraine Paterson	15		15	0	Achieved.	GREEN	GREEN	0	0
36	Community Dental Service	Review of community dental services and staffing levels.	Euan Thomson	25		25	0	Achieved.	GREEN	GREEN	0	0
37	Custodial Healthcare	Anticipated cost reduction in the provision of out of hours services in the Cowal and Helensburgh areas.	George Morrison	20		30	-10	Achieved.	GREEN	GREEN	0	0
38	Review of Budget Reserves	Review of uncommitted and discretionary spend budgets held in reserve. This relates to budgets where either Scottish Government funding has been received and not yet allocated or locally established budgets relating to forecast cost increases or service developments. For these monies the funds aren't released to managers until there is a clear spending plan, where these do not come forward the budget reserves can be undercommitted.	George Morrison	300		140	160	On track to be fully delivered.	GREEN	GREEN	0	0
39	Older People's Services	Undertake a longer term review of Council owned care homes across Argyll and Bute during 2016-17 with a view to reducing placement costs.	Allen Stevenson/ Lorraine Paterson		tbc		0	No specific target. References 55 to 57 are options to take this work forward.			0	
40	Learning Disabilty Service	Undertake a longer term review of Council run Learning Disability Day Services/Resource Centres during 2016-17 to establish demand in each locality and develop options for person-centred service re-design.	Allen Stevenson/ Lorraine Paterson		tbc		0	No specific target.			0	
41	Social Work Administration Staffing	Removal of vacant and temporary posts, will be implemented as part of a review of the administration services across the whole partnership.	Louise Long	100	5.0	100	0	Achieved.	GREEN	GREEN	0	
42	Reduce Printing and Postage Costs	Will be delivered through increased use of electronic communication such as email	Stephen Whiston	18	0.0	18	0	Achieved.	GREEN	GREEN	0	
43	Public Dental Service	Recurring allocations are included in the Health offer of funding. There has been a confirmed reduction to the Public Dental Service allocation which represents a 5% reduction. There has been a roll back of provision in advance of this reduction and the budget is forecast to be underspent by £205k in 2015-16. The reduction can be met through non-filling of vacant posts.	Euan Thomson	176	tbc	175	1	Achieved.	GREEN	GREEN	0	

INTEGRATION JOINT BOARD **APPENDIX 2**

QUALITY AND FINANCIAL PLAN PROGRESS - OCTOBER 2016

				TARGET 2016-17		Achieved October 2016	Remaining						
New Ref	Service Area	Description	Lead	Budget Reduction £000	FTE Reduction	£000	£000	Progress	ORIGINAL Risk of Delivery (RAG)	CURRENT Risk of Delivery (RAG)	Projected Shortfall 2016-17	Projected Shortfall 2017-18 onwards.
44	Reduction to Outcomes Framework Allocations	Recurring allocations are included in the Health offer of funding. A number of previous allocations issued separately have been rolled up into a new Outcomes Framework Allocation. This includes for example eHealth, Effective Prevention, GIRFEC, Policy Custody, Dental Services. The total funding was £2.2m in 2015-16 and the reduction represents a 5.5% reduction. A plan will be drafted for a targeted approach to a reduction from the Outcomes Framework allocations with a focus on reducing discretionary/non-recurring costs.	Liz Higgins Stephen Whiston Euan Thomson Elaine Garman	124		153	-29	Achieved.	GREEN	GREEN	0	
45	Ardlui Respite Facility	Services at Ardlui have consistently been charged for at the intensive service cost rate. Cost reductions could be achieved by reviewing the rates paid to the supplier to ensure that the appropriate rate is paid for each child.	Louise Long	10	0.0	0	10	Following a review of the demands, pressures and savings identified in May, this saving has been reviewed and up-to-date commitment data suggests that this saving will not materialise. However, the saving is fully offset by reductions in the forecast demand/cost pressure previously assessed against the Children's Houses and children with a disability on a recurring basis.	GREEN	RED	10	10
46	Other Residential Respite	Although an unpredictable budget, regular monitoring and control of services and costs could yield a cost saving over the year unless a high dependency case arises which uses up the funds available.	Louise Long	10	0.0	0	10	The 2016-17 saving will not be delivered due to demand for services for 2 high need clients. Expected to be delivered for 2017-18 as one of the two current high cost service users using this budget will transition to Adult Services.	GREEN	AMBER	10	0
47	Adoption	Review the payments made to adoptive parents where they are continuing to receive payments equivalent to the foster care rates in order to produce cost savings.	Louise Long	10	0.0	0	10	The 2016-17 saving will not be delivered due to increased demand for the service.	GREEN	AMBER	10	0
48	Children's Houses	Review the rotas operating in the children's houses to negate the affect of absence and assist with the additional support required by several high dependency young people. One area to consider is increasing the pool of staff to avoid anyone working beyond 37 hours per week drawing overtime costs.	Louise Long	30	0.0	30	0	Achieved.	GREEN	GREEN	0	0
49	Foster Care	Review one external foster care placement and move child to Shellach View/internal foster carer in order to reduce costs.	Louise Long	30	0.0	30	0	Achieved.	GREEN	GREEN	0	0
50	Residential Placements	Arrange to transfer three existing externally placed young people into the Council's children's houses at the earliest opportunity in order to reduce costs. Additional savings may be available within this activity but may be required to support Kinship Care Payments dependant upon the uptake of the new Kinship Care Orders.	Louise Long	22	0.0	0	22	Due to two new unplanned placements into external residential care this saving will not be realised in 2016-17. Plans are being developed to repatriate as many children back to Argyll as possible which could produce a saving in 2017-18.	GREEN	AMBER	22	0
51	Supporting Young People Leaving Care	Likely cost avoided from lead time to implement Alternatives to Care project.	Louise Long	17	0.0	22	-5	Increased saving delivered to compensate for the non-achievement of savings in relation to the Consultation Support Forum. This saving will not be recurring in 2017-18 when the new team is in place.	GREEN	AMBER	0	17
52	Consultation Support Forum	Likely cost avoided from lead time to implement revised service model.	Louise Long	5	0.0	0	5	A delay in the Life Choices Initiative is likely to lead to this saving being delivered in 2016-17 but this is not likely on a recurring basis.	GREEN	RED	0	5
53	Children Affected by Disability	Cost avoided due to clients transferring to Adult Services.	Louise Long	15	0.0	0	15	Based on current circumstances, this is on track to be delivered in 2016-17 on a recurring basis.	GREEN	GREEN	0	0

QUALITY AND FINANCIAL PLAN PROGRESS - OCTOBER 2016

				TARGET 2016-17		Achieved October 2016	Remaining					
New Ref	Service Area	Description	Lead	Budget Reduction £000	FTE Reduction	£000	£000	Progress	ORIGINAL Risk of Delivery (RAG)	CURRENT Risk of Delivery (RAG)	Projected Shortfall 2016-17	Projected Shortfall 2017-18 onwards.
54	Homecare Review	Comprehensive re-design to incorporate: - Integrating reablement services for assessment and care management - homecare procurement and external providers - change delivery model from time and task to outcome focussed - integrate external providers into assessment and care management process - delivering services on a patch basis to reduce unproductive time	Allen Stevenson/ Lorraine Paterson	375	0.0	193	182	The Commissioning Team have started to work on a patching model for service distribution across Argyll. £193k of this saving has been delivered in East Argyll but no progress has ben made in West Argyll to date. It is unlikely that the remaining £182k will be delivered in 2016-17 from West Argyll, there is the possibility of East delivering a little more as patching arrangements kick in. It is likely that all of the savings will be achieved on a recurring basis.	AMBER	RED	182	125
55	Struan Lodge Service Re-design	Re-design the service provided by the teams at Struan Lodge Care Home and Struan Day Service to end residential care on the site and instead create a community support hub which provides reablement, drop-in, assessment and review and day/social support to older people, including people with dementia, in the Cowal area. This would include a review of the vehicles used by the new service to support the provision of a community transport service for all client groups across Cowal (for example taking patients home from hospital etc.). As staff turnover allows, divert funds to support befriender schemes in Cowal to improve services in the community, supported from the hub. The lead in time for delivering on this could be significant as the service is re-designed.	Allen Stevenson	175	14.0	0	175	Decision taken at Special IJB meeting on 2nd November to pause implementation. No saving will be achieved for 2016-17. Assume as decision has not been reversed that this saving will still be achieved for 2017-18, and an additional saving would be achieved as this represented a part-year saving.	AMBER	RED	175	0
56	Thomson Court Day Service	Review model of dementia day service provision including the balance of funding to provide befriender services in and around Rothesay.	Allen Stevenson	10	3.0	0	10	Decision taken at Special IJB meeting on 2nd November to pause implementation. No saving will be achieved for 2016-17.	AMBER	RED	10	0
57	Tigh a Rudha Care Home	Realign capacity to match the level of service provision required, staffing is reduced in a stepped basis based on registration requirements. Review will look at usage of Hospital beds and will ensure that there is capacity for an element of growth.	Lorraine Paterson	18	1.5	18	0	Achieved.	AMBER	GREEN	0	0
58	Gortonvogie Care Home	Realign capacity to match the level of service provision required, staffing is reduced in a stepped basis based on registration requirements. Review will look at usage of Hospital beds and will ensure that there is capacity for an element of growth.	Lorraine Paterson	18	1.5	0	18	A review of the staffing structure is underway which is expected to deliver some savings most likely from 2017-18 onwards, the extent of which is still to be established. For 2016-17, the unit has over-recovered on income but this cannot be relied upon in future years.	GREEN	AMBER	18	0
59	Bowman Court Progressive Care Centre	Review overnight provision to share staffing resource across the progressive care centre and adjoining hospital. Increase the pool of bank staff based at the unit/work jointly with external providers to provide absence cover, eliminating unfunded overtime and mileage costs. Review grades and tasking of existing staff group to bring them into line with agreed homecare grades.	Lorraine Paterson	80	0.0	0	80	Discussions are ongoing regarding savings proposals put forward by the local management team. A staffing redesign is underway and although this will avoid excess costs, it will not facilitate a reduction in budget. Work remains outstanding in relation to the review of the grades of existing senior staff at the unit. The 2016-17 saving will not be delivered and it is doubtful that the full saving will be delivered during 2017-18.	AMBER	RED	80	80

QUALITY AND FINANCIAL PLAN PROGRESS - OCTOBER 2016

				TARGET 2016-17		Achieved October 2016	Remaining					
New Ref	Service Area	Description	Lead	Budget Reduction £000	FTE Reduction	£000	£000	Progress	ORIGINAL Risk of Delivery (RAG)	CURRENT Risk of Delivery (RAG)	Projected Shortfall 2016-17	Projected Shortfall 2017-18 onwards.
60	Sleepover Provision	Review overnight support services where it is deemed safe to do so and replace with telecare equipment and the local responder provision.	Allen Stevenson/ Lorraine Paterson	150	0.0	0	150	Work has been ongoing to review existing sleepover packages with a view to replacing with alternative care. Additionally, the Commissioning Team are reviewing how sleepovers are delivered to high risk clients going forward with a view to sharing support/moving to block arrangements where possible. It is expected that changes to packages will commence in early December however, due to the late start in reducing packages and the cost implication of new sleepover rates which address the National Living Wage and European Working Time Directive, the 2016-17 saving will not be achieved. The 2017-18 saving is expected to be achieved.	AMBER	AMBER	150	0
61	Internal Mental Health Support Team	Review the level of provision available from the community support team and the role of the internal mental health support worker to consider it if meets the requirements of the service and provides best value. Proposed saving reflects the underspend produced in 2015/16, this is expected to be recurring.	Allen Stevenson/ Lorraine Paterson	60	0.0	0	60	At the moment, given the pressures on the service it is unlikely that the full £60k saving will be delivered in 2017-18.	GREEN	RED	60	60
62	Assessment and Care Management Financial Assessments	Replace four para-professional LGE8 care managers with four LGE6 finance assistants and transfer responsibility for the completion of all financial assessments to the new staff group. Review of current posts including opportunities for accomodating through vacancies or natural turnover.	Allen Stevenson/ Lorraine Paterson	12	0.0	0	12	There are currently no temporary posts available to provide an opportunity to deliver this saving and so it is extremely unlikely that it will be delivered during 2016-17. Unless the implementation of the UAA (Univeral Adult Assessment) progresses dramatically over the next few months, it is unlikely that the 2017-18 saving will be delivered.	AMBER	AMBER	12	12
63	Assessment and Care Management Reduction	Remove 2 FTE para-professional care managers across Argyll to reflect the increased pool of staff within the partnership available to undertake assessment and care management work. This would also allow us to protect professional grade staff to ensure that there is capacity to meet the partnership's obligations in relation to adult protection. This cost reduction would capitalise on the benefit of Integration and economies of scale in terms of the staff resource, there would be training requirements but these would be addressed during implementation.	Allen Stevenson/ Lorraine Paterson	30	2.0	0	30	There are currently no temporary posts available to provide an opportunity to deliver this saving and so it is extremely unlikely that it will be delivered during 2016-17. . Unless the implementation of the UAA (Univeral Adult Assessment) progresses dramatically over the next few months, it is unlikely that the 2017-18 saving will be delivered.	AMBER	AMBER	30	30
64	Mid Argyll Dementia Day Service	Review service management arrangements for the Dementia Day Service in Mid Argyll and transfer responsibility to the manager at Ardfenaig. This could be achieved by temporarily redeploying the postholder to the MAKI HCPO post to cover 1 year secondment or into the Kintyre HCO post - both have been advertised.	Lorraine Paterson	18	1.0	0	18	The service has a plan in place to deliver this saving.	AMBER	GREEN	0	0
65	Support for Carers	Review the allocation of funding to carers support groups, establish how the funding is used, identify what supports are provided, ensure resources are targeted to support vulnerable carers, establish if best value is being delivered, disinvest during 2016/17 to gather resources for use in 2017/18 to support the introduction of the Carers Act. This would be a review of how this money is currently invested to ensure that value for money is being achieved and potentially achieving efficiencies.	Allen Stevenson/ Lorraine Paterson	75	0.0	9	66	The Commissioning Team have identified slippage on the spending of at least one group and are reviewing the funding allocation. It is unlikely that the remaining saving of £66k will be delivered in 2016-17. This saving was always intended to be a non-recurring saving for 2016-17 as the budget is required for investment in support for carers from 2017-18 onwards.	AMBER	RED	66	75

QUALITY AND FINANCIAL PLAN PROGRESS - OCTOBER 2016

				TARGET 2016-17		Achieved October 2016	Remaining					
New Ref	Service Area	Description	Lead	Budget Reduction £000	FTE Reduction	£000	£000	Progress	ORIGINAL Risk of Delivery (RAG)	CURRENT Risk of Delivery (RAG)	Projected Shortfall 2016-17	Projected Shortfall 2017-18 onwards.
66	Supported Living Services	Review existing supported living services to ensure that services are providing best value, are consistent with the partnership's priority of need eligibility criteria and that the non-residential care charging policy is being applied appropriately and consistently. Re-assessments would be carried out to ensure the appropriate level of service is being delivered, it is expected that this would deliver efficiencies and cost reductions.	Allen Stevenson/ Lorraine Paterson	100	0.0	0	100	The service is actively working with suppliers to review and reduce care packages where possible and it is expected that this target will be achieved, if not over-achieved for 2016-17. The service and commissioning team are confident that they can achieve this saving and potentially more going forward into 2017-18.	AMBER	GREEN	0	0
67	Learning Disability Day Services	Review internal day support provision for learning disabled clients.	Allen Stevenson/ Lorraine Paterson	110	0.0	49	61	The saving achieved for 2016-17 is as a result of vacant posts which will not be removed on a recurring basis. There review of the resource centres requires to be completed before the savings will be achieved on a recurring basis.	GREEN	RED	61	110
68	Homecare Packages	Review small number of high cost homecare packages to ensure that person centred care needs and outcomes are met but on an affordable basis through packages that provide value for money. This would involve looking at packages on a case by case basis and ensuring that processes are put in place to ensure best value whilst balancing this with meeting the need of individual clients.	Allen Stevenson/ Lorraine Paterson	200	0.0	103	97	Savings have been delivered in East Argyll, the remaining balance of £97k is not likely to be delivered in 2016-17. The ability to deliver the saving on a recurring basis will be dependent upon the success of service redesign work to intervene earlier in cases to prevent clients becoming high resource individuals.	AMBER	RED	97	100
		Total Budget Reduction		**8,498**	**103.1**	**3,423**	**5,075**				**3,544**	**1,656**

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INTEGRATION JOINT BOARD **APPENDIX 3**

FINANCIAL RISKS - OCTOBER 2016

				LIKELIHOOD		
Ref	**TITLE OF RISK**	**DESCRIPTION OF RISK**	**MITIGATIONS/ACTIONS IN PLACE**	**SCORE**	**OVERALL LIKELIHOOD**	**POTENTIAL FINANCIAL IMPACT £000**
1	Prescribing	Costs increase through national pricing agreements, new drugs are introduced, volumes dispensed increase.	Closer working with prescribers to ensure formulary compliance and Best Value.	4	Likely	500
2	Commissioned Services	The volume of high cost care packages increases	Closer scrutiny of applications for care packages.	4	Likely	250
3	Integrated Equipment Service	Demand for the community equipment service continues to grow and budget is under pressure, this is expected to increase with the shift in the balance of care.	Efficient running of Integrated Equipment Service, prioritisation of need and procurement processes.	4	Likely	200
4	Adult Care - Older People Service Demand	Demand for services for older people (ie over 65s) exceeds the demand pressure already factored into the budget.	Ongoing monitoring and reporting of service demand and provision costs to IJB management team.	3	Possible	600
5	Medical Locums	Need for use of locums continues in A&B Hospital, Lorn & Islands hospital and Mull GP services, and risk in other areas.	Pursue new models of service provision with NHS Glasgow and Greater Clyde and the local teams.	3	Possible	500
6	Adult Care - Younger Adult Service Demand	Demand for services for younger adults (ie under 65s) exeeds the demand pressure already factored into the budget.	Ongoing monitoring and reporting of service demand and provision costs to IJB management team.	3	Possible	300
7	Adult Care - Living Wage Provision	Additional funding is not made available to the IJB to fund the excess cost of implementing the Living Wage requirements. In addition residual risk in relation to the confirmation of uplift rates from providers outwith Argyll and Bute area.	Cost rates have been agreed with providers, approach to be made to the Council to request additional funding. Work with commissioning team to establish and agree uplift rates for providers outwith Argyll and Bute area.	3	Possible	150
8	Local Healthcare Treatments	Activity levels of locally provided treatments, eg urology, are not contained and grow significantly	Management of volume of service provided locally and re-design of pathways.	3	Possible	200
9	Children and Families - Children's Houses	Service unable to access and use all of the available capacity within the three children's houses due to the potential risks to others posed by specific existing residents.	Continuous review of the support required by and risks posed by the young people involved.	2	Unlikely	500

INTEGRATION JOINT BOARD **APPENDIX 3**

FINANCIAL RISKS - OCTOBER 2016

				LIKELIHOOD		
Ref	**TITLE OF RISK**	**DESCRIPTION OF RISK**	**MITIGATIONS/ACTIONS IN PLACE**	**SCORE**	**OVERALL LIKELIHOOD**	**POTENTIAL FINANCIAL IMPACT £000**
10	Children and Families - Continuing Care	Relatively new area of support for Looked After Children introduced under the Children and Young People Act. Unclear as to the expectations / wishes of the affected young people in relation to the support they need / want over the next year.	Ongoing monitoring and reporting of service demand and provision costs to IJB management team. Ensure that Argyll and Bute responds to any information requests from COSLA or the Scottish Government in relation to funding allocations for this service area.	2	Unlikely	300
11	Children and Families - Kinship Care	Demand for Kinship Care Allowances exceeds the budget provision and / or the awaited Scottish Government guidance leads to an increase in allowance values or the number of people who qualify for support.	Ensure that Argyll and Bute responds to any information requests from COSLA or the Scottish Government on the implications of any changes to guidance and / or funding allocations.	2	Unlikely	300
12	Children and Families - Children's Houses	Impact of additional staffing required to support young people with highly complex needs.	Intensive review of the needs and support requirements of the young people involved.	2	Unlikely	100
13	Children and Families - Child Protection	Inability to recruit suitably qualified and experienced social workers to manage and deliver child protection services.	Backfill vacant posts with agency staff where required. Adjust the hours worked by agency staff to contain costs within the budget available for the vacant post. *Agency staff may be required to provide full cover where the risks associated with partial replacement of vacant posts are too high and the Partnership is unable to meet its statutory child protection obligations.*	2	Unlikely	100
					TOTAL	**4,000**

INTEGRATION JOINT BOARD APPENDIX 4

OTHER PROJECT FUNDING

Integrated Care Fund

Project	Lead Officer	15/16 Carry Forward £'000	16/17 Allocation £'000	16/17 Budget £'000
Scottish Care Local Integration Leads	Liz Higgins		64	64
Business Transformation Officer Post (50% contribution)	Stephen Whiston		30	30
Project Manager	Stephen Whiston		36	36
Commissioning Posts x 2	Anne MacColl-Smith		96	96
Reablement Service	Linda Currie		234	234
Public Health Post	Alison McGrory		52	52
Care & Repair Team	Allen Stevenson		80	80
Oban, Lorn & Isles Locality Allocation	Lorraine Paterson	39	182	221
Mid Argyll, Kintyre & Islay Locality Allocation	Lorraine Paterson	82	201	283
Cowal & Bute Locality Allocation	Allen Stevenson	77	221	298
Helensburgh & Lomond Locality Allocation	Allen Stevenson	58	196	254
Integrated Equipment Store	Allen Stevenson		138	138
Management and Prevention of Falls	Linda Currie		41	41
Self Management Programme	Alison McGrory		14	14
Support Community Reablement & Intermediate Care	Locality Managers	40		40
Helensburgh block purchase of care at home for reablement	Linda Currie	20		20
Advanced Healthcare Monitoring System for Reablement Teams	Linda Currie	31		31
Increased Weekend Discharges	Viv Hamilton	0		0
X-PERT training programme for type 2 diabetes	Lorraine Paterson		9	9
Uncommitted Balance		41	246	287
TOTAL		**388**	**1,840**	**2,228**

Delayed Discharge

Project	Lead Officer	16/17 Allocation £'000	17/18 Allocation £'000
Helensburgh ICAT	Allen Stevenson	141	141
Islay Overnight Service (Carr Gorm)	Lorraine Paterson	45	45
Mull Overnight Service	Lorraine Paterson	45	45
Business Transformation Manager (Split 50/50 with ICF)	Stephen Whiston	29	29
Care First Enterprise License	Allen Stevenson	75	75
Uncommitted Balance		217	401
TOTAL		**552**	**736**

Technology Enabled Care

Project	Lead Officer	16/17 Allocation £'000	17/18 Allocation £'000
Home Health Monitoring		117	116
Digital Platforms / Living It Up		50	0
Telecare		180	124
Programme Management Costs		66	0
Telehealth Support Costs		21	0
Uncommitted Balance		151	0
TOTAL		**585**	**240**

Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Agenda item: 5.6ii

Date of Meeting : **30th November 2016**

Title of Report : **Budget Outlook 2017-18 and 2018-19**

Presented by : **Caroline Whyte, Chief Financial Officer**

The Integration Joint Board is asked to :

- **Note** the indicative budgets and resulting budget gap for 2017-18 of £10.0m and for 2018-19 of £6.4m
- **Approve** the development of the Quality and Financial Plan for the next two years in line with the estimated budget gap and the previously agreed timeline
- **Note** that further reports will come forward to the IJB on the budget outlook as and when further information becomes available
- **Note** the requirement for the IJB to approve a balanced Integrated Budget by 31 March 2017.

1. EXECUTIVE SUMMARY

1.1 The IJB is facing a challenging financial outlook with an estimated budget gap of £10.0m and £6.4m for the remaining two years of the Strategic Plan. There is a Quality and Financial Plan in place to address savings of £8.5m for 2016-17 and plans are underway to develop a Quality and Financial Plan covering the years 2017-18 and 2018-19.

1.2 A proposed timeline was agreed by the IJB at the development session on 28 September for the development of plans, this work is currently underway and progress will be reported to the IJB at the further development session planned for 13 December.

1.3 Indications are that one-year financial offers will be submitted by both partners, this does not preclude the IJB from planning for a two year budget from 2017-18 to 2018-19 to sit alongside the delivery of the Strategic Plan. There are significant cost and demand pressures due to the nature of services delivered and this is likely to be a continuing trend in future years with an ongoing requirement to address a funding gap. The changes required to service delivery are significant and the transformational change can only be delivered if services have the appropriate time to plan and implement savings.

1.4 There is a significant degree of uncertainty around the level of funding available and the funding of cost and demand pressures. The uncertainty is particularly around the level of funding available from the Council, the estimated position for the IJB represents the current worst case scenario for the Council, but also assumes that all cost and demand pressures will be funded before a saving is passed to the IJB. The Council will not receive their settlement from the Scottish Government until the middle of December and this is the area that provides the Council with the greatest degree of uncertainty.

1.5 The financial assumptions and budget outlook will be updated as more information becomes available and there is more certainty around the budget allocations available, the most up to date position will be presented to the IJB at the earliest opportunity.

2. INTRODUCTION

2.1 The Integration Joint Board is required to allocate the resources it receives from the Health Board and Council in line with the delivery of the Strategic Plan. The Board is able to use its power to build up reserves so that in some years it may plan for an underspend to build up reserve balances and in others to break-even or to use a contribution from reserves in line with a reserves policy. The IJB currently don't have any balances held in reserves.

2.2 The approach to the budget planning for 2017-18 and 2018-19 is set out in the scheme of integration as an incremental approach using the 2016-17 budget as a baseline, taking into account cost and demand pressures, inflation and the impact of previously agreed budget savings. This approach to building up costs when compared with the funding available will inform the IJB on the overall budget gap to be addressed for the remainder of the Strategic Plan.

2.3 The updated budget outlook for 2017-18 and 2018-19 is set out in the report. There are significant cost and demand pressures to be funded and these give rise to the overall budget gap. A Quality and Financial Plan will require to be developed and approved by the IJB by 31 March 2017 to ensure the delivery of a balanced budget.

3. DETAIL OF REPORT

3.1 BASELINE BUDGET 2016-17

3.1.1 The starting point for developing the budget for 2017-18 is to use the 2016-17 budget allocation as a baseline position.

3.1.2 The base budget for 2016-17 is outlined in the table below:

	2016-17		
Partner	**Approved Budget £m**	**Reported Position £m**	**Difference £m**
Health	195.868	197.184	1.316
Council	55.553	55.727	0.174
Additional SG Funding	4.580	4.580	0.000
Partnership Total	**256.001**	**257.491**	**1.490**

3.1.3 The difference in the overall funding in 2016-17 is mainly due to the allocation of additional non-recurring budgets or funding during the year, therefore the planning assumption should be based on the original approved baseline budget for 2016-17.

3.2 COST/DEMAND PRESSURES AND INFLATION

Cost and Demand Pressures

3.2.1 Cost and demand pressures in relation to both health and social care services are expected to outstrip any available funding uplifts and will have a significant contribution to the overall budget gap. There is some uncertainty around the funding of cost and demand pressures, particularly in relation to some of the anticipated pressures from the delivery of social care services and whether additional funding will be passed over from the Scottish Government to fund these. The final position will not be known on this until the Local Government Spending Review has been concluded.

3.2.2 The cost and demand pressures noted below require to be included in the updated budget outlook:

Cost/Demand Pressure	**2017-18 £m**	**2018-19 £m**
Health Care Packages - Unfunded and New Packages	0.550	0.250
GG&C SLA - growth from new treatments	0.800	0.800
Prescribing Growth	0.579	0.579
Health - Apprenticeship Levy	0.295	0.000
Health - NDR Revaluation	0.250	0.000
Remote and Rural Project	0.223	0.000
Other existing Health Pressures	0.204	0.000
Other new Health Pressures	0.161	1.000
Adult Care Growth	1.200	1.200
Younger Adults supported living	0.300	0.300
Living Wage - full year impact	1.410	0.000
Carer's Act	0.000	0.400
Continuing Care	0.500	0.735
Auchinlee Care Home	0.334	0.000
Sleepovers – Children's Services	0.116	0.000
Criminal Justice Services	0.132	0.000
Unaccompanied Asylum Seekers	0.473	0.000
TOTAL	**7.527**	**5.264**

3.2.3 The social care cost and demand pressures outlined above represent the expected worst case scenario outlined in the Council budget outlook. In the budget outlook there is an assumption that all of the cost and demand pressures will be added to the overall Council funding gap before this position is allocated to services, there is no indication that the IJB would need to directly fund the social care cost and demand pressures over and above an allocated share of the budget gap. In addition there is an expectation that additional

funding will be provided by the Scottish Government to fund some cost pressures, for example the full year cost of the Living Wage commitment.

3.2.4 The cost and demand pressures are the main contributing factor to the overall financial gap, as such the Integration Joint Board should scrutinise these suitably to ensure that these are valid and necessary in terms of delivering the outcomes in the Strategic Plan. Further detail on the cost and demand pressures together with the reasons for including them in the draft budget will be provided in a future report.

3.2.5 A cost pressure is included for Criminal Justice services, this represents the additional cost as West Dunbartonshire Council will no longer continue the court service from April 2017. The Children and Families service are currently considering the future of the delivery of services for Criminal Justice Social Work. The funding for the service is being reviewed as part of the Local Government Finance Settlement and a further report will be presented to the IJB in the future to take a decision on the model of service delivery.

Inflation

3.2.6 The current expected inflationary increases to the baseline budget are noted below:

Inflation	**2017-18 £m**	**2018-19 £m**
Pay Inflation - assumed 1% pay award all employees	1.057	1.057
Prescribing & medication - cost growth 2%	0.436	0.436
GG&C SLA - 1.8% uplift	0.980	0.980
Other Health SLAs - 1.8% uplift	0.268	0.268
Other Health - including energy costs	0.145	0.145
Living Wage - increase from £8.25 to £8.45 p/h	0.698	0.698
Other Social Care Increases	0.068	0.068
TOTAL	**3.652**	**3.652**

3.2.7 Inflation is only applied to service budgets where it is deemed to be unavoidable, therefore there is no general inflationary increase for costs applied to any service budgets.

3.3 FUNDING ESTIMATES

3.3.1 The IJB were given funding allocations for one year only for 2016-17. There is a degree of uncertainty around the level of funding that will be available from 2017-18 onwards, however the estimated position together with the assumptions are noted below.

Health Funding

3.3.2 The table below outlines the estimated funding available from NHS Highland:

Health	**2017-18 £m**	**2018-19 £m**
Opening Balance:		
Baseline	165.229	168.203
Annual allocations	22.289	22.289
Non Discretionary Primary Care Services	8.350	8.350
Total Baseline Funding	**195.868**	**198.842**
1.8% Uplift	2.974	3.028
Total Health Funding	**198.842**	**201.870**

3.3.3 The Scottish Government have advised Health Boards to plan on the assumption that a 1.8% uplift will be applied to the baseline Health budgets for 2017-18 and 2018-19. There are number of annual allocations, including non-recurring in-year allocations, the funding for 2017-18 onwards is unknown at this stage, however these funds are targeted as specific issues and there would be an expectation that any changes in the level of funding would result in an offsetting increase or decrease to service budgets. The funding in relation to Non Discretionary Primary Care Services reflects a reimbursement of costs, rather than funding to be allocated to services, any change in this value would have no impact to the bottom line position.

Council Funding

3.3.4 The Council are yet to provide formal indication of the funding available, but the local government finance settlement is for one year only so it is likely that there will be a one year offer of funding for 2017-18. The final position will not be confirmed until the Council approve their budget in February 2017. There is a significant risk for the IJB in relation to the level of funding available from the Council.

3.3.5 The Council will not be advised of their financial allocation from the Scottish Government until the middle of December, this makes planning difficult as the largest proportion of their funding comes from the Scottish Government. The Council have considered a budget outlook report which contains a range of financial assumptions based on the best and worst case scenarios for the totality of the Council budget. These forecasts would result in savings ranging from best case 2.2% and worst cast 7.3% reductions to Council services for 2017-18, with further reductions of between 4.1% and 7.8% in 2018-19. There is nothing to indicate that IJB would be treated differently to other Council services, however this has not been formally communicated or confirmed. It is also possible that the Scottish Government may impose restrictions via the spending review on the budget reductions that local authorities can pass onto IJBs in order to protect Integration Services.

3.3.6 The table below outlines the estimated funding available from Argyll and Bute Council:

Council	**2017-18 £m**	**2018-19 £m**
Baseline Funding	55.553	57.196
Additional Funding for Cost & Demand Pressures, Inflation etc	5.698	3.868
Total Baseline Funding	**61.251**	**61.064**
Estimated Reduction	(4.055)	(4.333)
Total Council Funding	**57.196**	**56.731**

3.3.7 As noted previously the current presentation of the Council budget outlook assumes that all cost and demand pressures and inflationary increases will be accommodated from within the Council budget before the budget gap is identified to be delivered from savings. This is illustrated above by assuming that for example in 2017-18 £5.698m of cost and demand pressures will be fully funded by the Council, or partly by the Scottish Government via the Council.

3.3.8 The estimated reduction in funding is based on the Councils current worst case scenario for both years, this would represent a 7.3% reduction in 2017-18 and a further 7.8% in 2018-19. The best case scenario would be a reduction of £1.2m (2.2%) and £2.3m (4.1%) for 2017-18. There is uncertainty around the Scottish Government spending review and funding reductions for local authorities, most of the Council funding is from the Scottish Government, therefore it would be prudent for the IJB to use the Council's worst case scenario for planning purposes at this stage. This will become clearer when the finance settlement is announced in the middle of December.

3.3.9 There is an assumption that the additional Scottish Government Funding of £4.580m will be baselined into the IJB funding allocation for 2017-18. Indications are that there will be additional funding of between £60m and £70m allocated to IJBs in 2017-18 to compensate for full year cost of the Living Wage implementation. The IJB share of this funding, if based on the previous allocation basis, would not be sufficient to accommodate this additional cost. The increase in costs in relation to the Living Wage have been incorporated into the cost and demand pressures and inflation estimates.

3.3.10 The overall total funding estimates are noted in the table below:

All Funding	**2017-18 £m**	**2018-19 £m**
Health	198.842	201.870
Council	57.196	56.731
Additional SG Funding	4.580	4.580
Total Estimated Funding	**260.618**	**263.181**

3.4 IMPACT OF 2016-17 BUDGET POSITION

3.4.1 The financial position for 2016-17 is outlined in the October budget monitoring report which is also presented to the IJB in a separate report. The financial position for 2016-17 impacts on the budget for future years as there are implications from not delivering previously approved recurring savings, the projected outturn position for the current year and the requirement to re-instate project funding.

3.4.2 There were savings of £8.498m approved for 2016-17. There has been a significant risk with the delivery of the level of savings in the Quality and Financial Plan and the routine monthly budget monitoring reports have been highlighting a projected shortfall in delivery of savings for 2016-17. As at October £3.5m of savings are not expected to be delivered during the current year. This position contributes to the overall projected outturn position for 2016-17. A detailed assessment has been carried out for each of the savings included on the plan and it is estimated that £1.656m of savings approved in 2016-17 will not be deliverable on a recurring basis, further detail is included in the budget monitoring report. As these savings are not deliverable on a recurring basis and these were required to balance the 2016-17 budget, this amount will require to be added to the overall budget gap for 2017-18 onwards and alternative savings will require to be identified as part of the development of the Quality and Financial Plan. The IJB would require to take a decision on removing these savings from the Quality and Financial Plan as these have previously been formally approved. This could be incorporated into the budget planning process and the IJB should consider the additional information they may require from services to enable a decision to be taken to remove the savings from the Quality and Financial Plan for 2017-18.

3.4.3 The projected outturn position for the Integrated Budget at the October budget monitoring period is an overspend of £1.240m, further detail on this position is included in the budget monitoring report. The Scheme of Integration outlines that *"where recovery plans are unsuccessful and an overspend occurs at the financial year end, and there are insufficient reserves to meet the overspend, then the Parties will be required to make additional payments to Argyll and Bute Integrated Joint Board…..Any additional payments by the Council and NHS Highland will then be deducted from future years funding/payments".* There will be further due diligence at the year-end and negotiations around any balance that would be deducted from the 2017-18 allocation of funding. The position is only a projection at this stage, but for planning purposes it is prudent to assume that the current forecast overspend would result in a reduction in funding in 2017-18 and should factor into the overall budget gap.

3.4.4 As part of the financial recovery plan it was agreed to review spending plans against non-recurring funding allocations with a view to removing uncommitted elements to bring the 2016-17 position back into balance. As a result of this there were underspends in relation to project funding for example the Integrated Care Fund which have not been fully committed. This funding totalling £0.500m will require to be re-provided in 2017-18.

3.4.5 As a result of the financial position for 2016-17 with the expectation that savings will not be fully delivered and that financial balance will not be achieved the overall impact is that £3.396m of additional savings will require to be added to the Quality and Financial Plan for 2017-18.

3.5 BUDGET GAP PROJECTIONS 2017-18 AND 2018-19

3.5.1 The Integration Joint Board has a responsibility to set a balanced budget and to delegate resources back to the Council and Health for the delivery of services in line with the Strategic Plan. The funding and cost estimates are prepared for each partner separately but these should be viewed by the Integration Joint Board as contributing to one Integrated Budget with one bottom line position. It will not necessarily be the case that the same level of resource will be delegated back to each of the partners and the development of the Quality and Financial Plan and the services changes included in that will determine the split of resources.

3.5.2 There will be one-year offers of funding from Council and Health partners for 2017-18, however the intention is for the IJB to approve a two year budget and take decisions about transformational changes to service delivery for a two year period in line with the Strategic Plan, this will also reflect the lead-in time for implementing the service changes and delivering the savings.

3.5.3 The Integrated Budget summary is noted below, together with the resulting overall budget gap for the next two years:

	2017-18 £m	**2018-19 £m**
Baseline Budget	256.001	260.618
Cost and Demand Pressures	7.527	5.264
Inflation	3.652	3.652
Total Expenditure	267.180	269.534
Total Funding	(260.618)	(263.181)
Budget Gap	**6.562**	**6.353**
Quality and Financial Plan 2016-17	1.656	0.000
Projected Outturn 2016-17	1.240	0.000
Re-instate Project Funds	0.500	0.000
Updated Budget Gap	**9.958**	**6.353**
% age of Baseline Budget	**3.9%**	**2.4%**
Cumulative Budget Gap	9.958	16.311

3.5.4 The estimated Integrated Budget gap for 2017-18 is £9.958m and for 2018-19 is a further £6.353m. There are a number of high level assumptions and estimates included within this position and these will be subject to change, however this is the best estimate we have based on the information available and these are the planning assumptions that should be used for developing the Quality and Financial Plan for 2017-18 and 2018-19.

4. CONTRIBUTION TO STRATEGIC PRIORITIES

4.1 The Integration Joint Board has a responsibility to set a budget which is aligned to the delivery of the Strategic Plan and to ensure the financial decisions are in line with priorities and promote quality service delivery.

5. GOVERNANCE IMPLICATIONS

None

5.1 Financial Impact

5.1.1 The Board is required to set a balanced budget for 2017-18, the Quality and Financial Plan is being developed to ensure this can be achieved within the required timescale.

5.2 Staff Governance

None

5.3 Clinical Governance

None

6. EQUALITY & DIVERSITY IMPLICATIONS

None

7. RISK ASSESSMENT

None, financial risks are noted in the report.

8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

8.1 Where required as part of the development and delivery of the quality and financial plan local stakeholder and community engagement will carried out as appropriate in line with the re-design of service provision.

9. CONCLUSIONS

9.1 The report outlines the estimated budget gap for Integrated Services for 2017-18 and 2018-19, and these are the planning assumptions that should be used in the development of the Quality and Financial Plan required to be prepared to deliver a balanced budget position. The 2016-17 financial position, with savings not being delivered in full and other cost and demand pressures resulting in a projected overspend position is placing additional pressure on the budget position for 2017-18 and additional savings will require to be identified as a result of this.

9.2 There is a degree of uncertainty around the funding available from the partners, particularly from the Council and the funding of cost and demand pressures. The level of cost and demand pressures is significant and is the main reason for the continuing funding gap. The financial assumptions will be kept under review with any changes to the forecast position being reported to the IJB at the earliest opportunity.

9.3 The Council and Health positions are not noted separately in the report as the Integration Joint Board should view the contributions as one Integrated Budget with flexibility to distribute as required to ensure priorities in the Strategic Plan are met. The 2016-17 financial year resulted in both partners having the same level of resources delegated back to them to fund services, this was the first year of integration, it is unlikely that this will be the approach in future years.

9.4 The future outlook for the Integrated budget is one of a continuing funding gap, mainly due to any uplift in funding being outweighed by increased costs due to demand and inflationary cost increases. The process is underway for the development of options to be included in the Quality and Financial Plan for 2017-18 and 2018-19 and the progress will be presented to the IJB at the December development session.

Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Agenda item: 5.8

Date of Meeting: **30 November 2016**

Title of Report: **Evaluation of Campbeltown Hospital Dialysis unit Pilot**

Report Prepared by : **Kristin Gillies, Senior Service Planning Manager**

Presented by : **Stephen Whiston Head of Strategy Planning & Performance**

The Integration Joint Board is asked to:

- Consider the outcome of the evaluation of the pilot
- Consider and approve the recommendation to continue the Dialysis service and expand its catchment area to cover Mid Argyll
- Consider the implications for the rest of Argyll and Bute and identify any action to be taken.
- Consider a scoping exercise to look at the viability of a Dialysis Unit within Bute.

Executive summary:

The Kintyre Community Dialysis Unit has been treating patients since August 2015 and it was agreed that the service would be a pilot for 1 year and then be evaluated. This paper details the full evaluation of the Unit and demonstrates that the unit has been very successful in delivering the new Hub and spoke model of dialysis to remote and rural Kintyre, reducing travel and improving the health and wellbeing for patients. The success of the Unit has also demonstrated that this model could potentially be replicated elsewhere in Argyll and Bute.

The outcomes from the evaluation were:

- Five staff continue to provide a high level of specialist dialysis treatment locally, ensuring the patients benefit from more flexibility to receive dialysis in bad weather as one patient lives on an Island.
- Patients have reported improved health and well being with the reduction in travel.
- NHSGG&C are support the quality and standard of unit and confirmed their continued support for the future.
- In financial terms the reduction in travel costs have offset the ongoing staff and equipment costs
- There will be ongoing costs associated with the running of the Unit, however providing Holiday Dialysis is an option the Hospital could explore.

The final part of the paper examines the demand for dialysis treatment in the other areas of Argyll and Bute, and the paper recommends that due to the current number of patients

and the Island location, further scoping work should be done on Bute to assess whether a similar Unit is a viable option there.

1. Introduction:

The purpose of this paper is to allow the HSCP Integrated Joint Board an opportunity to consider the findings of the evaluation of the Campbeltown dialysis pilot and assess where the implications of the findings sit within its strategic plan and service priorities.
The criteria which will be used to assess and evaluate the success and model of dialysis service provision will be:

- **Demand and Utilisation**
- **Accessibility**
- **Renal Unit staffing (capacity and skills)**
- **Clinical outcomes for patients and patient experience**
- **Financial implications**

The kidneys are organs that primarily excrete waste from the body in the form of urine.
Dialysis removes the waste products from the body that build up when the kidneys fail in order to maintain life. If the kidney function is reduced to 15% of normal due to disease, patients experience established renal disease (ESRD). A person with ESRD will die within weeks or months unless they receive renal replacement therapy (kidney transplantation or dialysis (peritoneal dialysis, home dialysis or hospital dialysis).

The numbers of patients requiring hospital dialysis Renal Replacement Therapy (RRT) are relatively small. However, the chronic nature of their problems, the effectiveness of RRT (without such treatment patients would die within six months of presentation) and the high cost of provision, make their needs an important consideration to inform planning for future health needs.

2. Background

In December 2012 NHS Highland conducted a viability review to consider the need for a Low Maintenance Dialysis Unit (LMD) in Lorne and Islands Hospital in Oban. The outcome of this review concluded that it was not a priority at that time to establish a local unit in the area. However two recommendations were made:

- Improved patient transport provision should be put in place for patients.
- The viability review should be revisited in 2015/16.

These recommendations resulted in the British Red Cross being commissioned to provide an improved patient transport service for patients accessing hospital dialysis services outside Argyll and Bute. The Argyll and Bute CHP committee agreed to revisit the viability review in 2015/16.

3. Kidney Dialysis Unit Campbeltown

In the spring/summer of 2014 as part of a practice/professional development project one of the Dialysis Nurses at the Vale of Leven (VOL) renal Dialysis unit undertook a project to examine if there was a service model to provide hospital dialysis locally for Kintyre residents who were undertaking a 6 hour+ round trip 3 times a week for renal dialysis. Through changes in practice and the support of the specialist team in NHSGG&C the nurse identified that an innovative hub and spoke outreach community dialysis unit could be provided at Campbeltown hospital linked to NHS GG&C. The assessment of current and future demand

and likely catchment area (Kintyre, Mid Argyll and Islay) identified the need for 2 dialysis chairs and machines. The plans evolved and 2 single rooms were joined together within the inpatient ward to create a small Dialysis Unit.

The local community and a number of Kidney Dialysis voluntary groups/charities expressed their immediate support to fund the capital and staff training costs to establish the unit in the hospital. In addition the West of Scotland renal planning group endorsed the proposal as a pilot to be evaluated after 1 year examining patient experience, suitability, safety, sustainability and quality of service.

The innovative nature of this hub and spoke model, the enthusiastic support of the community and stakeholders and the support of NHSGGC re clinical networks, governance decision support and the loan of 2 dialysis machines and chairs led the Argyll and Bute CHP to consider the merits of this proposal including how to fund the revenue costs of the unit (staff, maintenance, consumables etc).

The proposal for a Hub and Spoke model of a community hospital renal dialysis service within the CHP was presented to the Core Management Team in September 2014 and after considerable deliberation a decision was made to undertake a pilot within Campbeltown.

4. Evaluation

4.1 Renal Unit staffing (capacity and skills)

A Cohort of 5 Registered Nurses 2 Band 6 and 3 Band 5 was identified to provide the service and the local team were enthusiastic to support the service from Campbeltown hospital. They went to the Vale of Leven hospital to train as Dialysis nurses. 1 Band 5 nurse was recruited to backfill the dialysis sessions.

All staff work very closely with the staff in the Vale of Leven Renal Unit and Dr Daly who provides Consultant care and clinical leadership to the Unit. The nurses have also gone for refresher training when they felt it was necessary and to ensure their confidence is maintained. The staff have been commended for the level of care and skill they demonstrate to the local patients.

The Dialysis unit has been very flexible in meeting the needs of the patients, especially one of the patients who lives on Island of Gigha and has experienced issues due to the weather and getting off the Island for dialysis. Previously this patient would have to stay near the Vale of Leven to ensure access to dialysis in some weeks in winter when the weather prevented the Ferry sailing.

There was only one occasion in the year of the pilot when a GP had to respond to a patient becoming unwell in the Unit and this was due to a chest infection. The Unit is fully nurse led and has not required GP input for any related dialysis concerns.

As the patient numbers have decreased since the decision to open the unit from 4patients to 2 patients, the Dialysis sessions take place on a Monday, Wednesday and Friday mornings. There is therefore capacity in the afternoons for more patients to dialyse.

4.2 Clinical outcomes for patients/Kintyre Patients (n=2) Feedback/Patient interviews

There are now two patients living in the Kintyre area who receive hospital based haemodialysis treatment 3 days in (Monday, Wednesday and Friday) every 7.

One patient is male and one female, both are in the age group 70+. Both patients used to travel to Vale of Leven hospital using Red Cross transport. Both patients agreed to participate in this study and provided the information shown below:

4.2.1 Kintyre Patient 1

Patient 1 has required haemodialysis for approximately 3 years.

Patient 1 described the previous experience of travelling to and from Vale of Leven Hospital, saying the journey plus treatment took 12 hours in total, or possibly longer if the A road access was closed for any reason (adverse weather or road traffic accident) and the transport was then diverted to the much slower B road. The experience was made worse because of travel sickness and would always vomit in the ambulance. The following day the patient would be completely exhausted and unable to get out of bed, which effectively meant that with 3 days of treatment and 3 days of recovery from the journey, only had 1 day each week in which to participate in family life. Now the patient only has a 2 or 3 minute car ride to and from the hospital following the opening of the Campbeltown Unit.

Things are much different now, following treatment the patient takes a short nap and is then able to get up and cook dinner for the family.

There are many activities of daily living that the patient now fully enjoys. Going shopping, doing the housework and laundry and cooking the meals, going out for a stroll with friends and enjoying a social life.

The greatest impact has been on the extended family. Patient 1 feels that not only has their own well-being improved, but also that of the partner, as their relationship has returned to normal. The patient has three granddaughters who live locally, two of whom are still at school. It is a great joy to Patient 1 that they can now see them daily and feels well enough to enjoy their company, whereas they used to see them only once a week.

This patient has two main concerns: firstly the status of the arteriovenous fistula – they have had four fistulae constructed, the first three failed and now fears that the fourth may not remain viable; secondly, they were completely clear in saying that they would not consider resuming travel to Vale of Leven Hospital for dialysis. If that were the only option patient 1 would choose to die.

The patient said the nursing staff are marvellous and very kind, they take great care of all the needs of the 2 patients that use the unit.

4.2.2 Kintyre Patient 2

Patient two has required haemodialysis for approximately 2 years and lives in an island location, with family. Patient two's travel time is now 3 hours per day, as compared to around 6.5 hours travelling to Vale of Leven Hospital (this includes ferry crossing time). Patient 2 has experienced occasions when he could not return home because the ferry had stopped operating, and has an arrangement with a farm on the mainland, where he can stay in this situation.

Patient 2 feels a little tired after dialysis, but can just sit in a chair and read a newspaper, as there is family care at home.

The change of location for treatment has made less difference to patient 2, although completely happy with the new unit and does not wish it to change again. However sometimes Patient 2 used to enjoy the journey to Vale of Leven Hospital, and enjoyed the company of the driver.

Patient 2 would not be really bothered if the treatment moved back to Vale of Leven Hospital, although prefers to have it in Campbeltown.

Patient 2 is very happy with all treatment received in Campbeltown but prefers not to have too much information and likes to leave it to the professionals. Patient 2 detailed that the nurses take excellent care of all the patients needs.

4.3 Feedback from Glasgow

The whole team in Glasgow has been extremely positive regarding how the Hub and Spoke model works. The team consists of Consultant Dr Daly, Charge Nurses Gail Dunsmore and Margaret McPherson and the Stobhill Techs Lead by Graham Craig. The team have given the local service much guidance and support over the last year.

"The Campbeltown unit has reduced the patients travel time significantly and on speaking to staff in the unit, it appears that patients well being has improved noticeably. The level of clinical support required by the staff in Campbeltown from GGC has been minimal, due to the staff coping with all issues independently and contacting us when necessary. The spoke and hub model has been a great success and hope that it can be continued and replicated elsewhere." (Charge Nurse Vale of Leven Renal Unit.)

The maintenance of the machines has been provided from the Stobhill team and they have provided a very fast and responsive service to the Unit. Overall the model has allowed all the dialysis sessions to take place when required and no sessions have been lost due to machine breakdowns.

4.4 Financial analysis and implications

The capital costs for the build of the Unit and purchasing of equipment etc was financed by charitable donations from the local community dialysis support group, local businesses, funeral donations and local people donating to the hospital fund through fundraising events.

Below is a breakdown of the total amount donated within the fund.

Kintyre Dialysis Support Group Endowments Fund

	£
Income	
Donations	114,724
Recovery of VAT on Professional Fees	2,975
Recovery of VAT on Interim Building Certificates	2,680
Recovery of VAT on Final Building Certificate	299
Gains/Losses on Investment	338
Dividends	1,906
Interest	6
Total	**122,928**

Below is a breakdown on the expenditure against the endowment fund.

Expenditure	**£**
Fees	(17,850)
Construction of Dialysis Facility	(89,378)
Equipment	(8,411)
Gifts	(78)
Endowment Fund Admin Costs	(1,285)
Dialysis Sundries	(10,829)
Total	**(127,829)**
Remaining Balance	**(4,901)**

The British Kidney Patient Association agreed to pay £42,700 of the training/accommodation and backfill costs associated with the training of the 5 nurses. Unfortunately due to staff sickness on the Acute ward for the period of the training, Agency nurses had to be used to cover the ward and so the Locality funded the £17,891 the additional costs.

Nurse Staffing Training Income and Expenditure

Income	**£**
British Kidney Patient Association	42,700
	42,700
Expenditure	
Training Backfill - Agency Nursing	(29,225)
Training Backfill - Bank Nursing	(13,312)
Travel and Subsistence for Training	(18,054)
	(60,591)
Contribution by Kintyre Locality	**(17,891)**

Patient Travel Costs

As detailed above, prior to the Unit opening in August 2015, patients had to travel to the Vale of Leven hospital 3 times a week which cost Argyll and Bute CHP £65,210. This has been significantly reduced following the opening of the unit and only £381 was spent taking the patients to Glasgow for appointments and £5954 was spent transporting the patients from their homes to the unit. This is detailed in the table below.

Patient Travel Costs - Highland & Islands Travel Scheme	**£**
Aug 2014 to July 2015 Travel Costs to GGC Renal Units	65,210
Aug 2015 to July 2016 Travel Costs to Campbeltown Unit	(6,335)
Reduction in Patients Travel Costs	58,875

Dialysis unit Recurring Revenue Costs	**£**
Band 5 Nurse	(45,000)
Band 6 Nurse (Supervision)	(3,000)

Dialysis Sundries	(10,800)
Total	**58,800**

Dialysis Chairs

NHSGG&C agreed to loan 2 Chairs and 2 machines to the Unit for the duration of the pilot. Due to capacity issues in Glasgow, the machines are required to be returned as soon as possible. The outcome of this evaluation is required in advance of purchasing new machines and chairs. There was initial agreement from the Community Dialysis support group to fund this purchase; however it is not known whether this is still a possibility as we are unclear as to whether there are the funds available to support this. If agreement is given by the IJB to agree the continuation of the Kintyre Dialysis Unit, further discussions would be required with the local support group, or a bid for NHS Capital funds. The costs are shown below.

Year 2 Capital Purchase costs	**£**
2x Machines	(26,000)
2x Dialysis Chairs	(5,500)
Total	(31,500)

Potential income – Holiday dialysis

Over the last year there have been 4 requests for patients to use the Kintyre Unit for holiday dialysis. It was agreed at the start of the pilot that holiday patients would not be accepted due to the level of experience of the nurses and some of the added complications holiday dialysis can present (infection risks to the machines) as the patients are not well known to the staff.

This however, is something the staff in Campbeltown are keen to look at again. The table below details costs other hospitals charge for holiday dialysis. Having looked at some very rough calculations, which would require further examination, it is thought Kintyre Dialysis Unit could charge £250- £300 per session.

Location	**Cost per session**
Inverness (Raigmore/ Belford)	£393 per session
NHS Greater Glasgow	£223 per session
London – St Thomas	£300 per session

5. Conclusions / Recommendations

The establishment of the pilot in Campbeltown was to address the following:

- Demand and Utilisation
- Accessibility
- Sustainability of staffing (capacity and skills)
- Clinical outcomes for patients and patient experience
- Financial implications

The evaluation has clearly demonstrated that the unit has operated successfully and safely meeting clinical outcomes and patient needs.

The use of the unit has fallen due to the reduction in patient numbers who require his level of service in the Kintyre locality.

Financially due to the tremendous support of the local community the unit's significant capital costs were fully funded. The staff recruitment and training costs have been met by the locality and the dialysis kidney association contribution.

The recurring revenue costs of the staffing have been met by the saving in transport costs. There remains however, the need to purchase 2 dialysis chairs and machines. Funding for this remains to be identified as there seems some uncertainty as to whether this will be met by the community. This is therefore a financial risk to the HSCP and clarification over this and NHSGG&C position is required.

In conclusion it can be assessed that the unit has proved successful meeting all the evaluation criteria and it is recommended the IJB approve its continuation as a core service expanding its catchment area to cover Mid Argyll.

6 Implications for Renal Dialysis provision in Argyll and Bute.

6.1 Demand and Utilisation across Argyll and Bute.

In Argyll and Bute there are a total of 10 patients currently using dialysis as a treatment for ESRD (October 2016).

Table 1: A&B current Dialysis patient numbers, by location and Dialysis centre.

Location	Number of patients, Dialysis centre
Oban	1 (Belford)
Campbeltown	2 (Campbeltown)
Mid Argyll	1 (Vale of Leven)
Bute	6 (Inverclyde)

1 patient lives in the Oban & Lorn area, and travels to the Belford Hospital in Fort William for haemodialysis. This journey takes 1 hour 11 minutes.

2 patients live in Kintyre, they have been using the local facility in Campbeltown hospital for the last year. Prior to that being available they made a 230 mile round-trip to the Vale of Leven hospital, 3 times each week. This involved leaving Campbeltown at 08.00 and returning home at approximately 20.00 on every dialysis day.

1 patient lives in Mid Argyll and travels to the Vale of Leven Hospital for dialysis. There are clinical discussions taking place to assess whether this patient is well enough to dialyse in Campbeltown. The current journey time for this patient is 1 Hr 30 minutes?

6 patients live on the Isle of Bute. Of these, one patient has in-home dialysis facilities. The remaining 5 patients travel by ferry and road to Inverclyde Hospital for dialysis. Currently there is a variance on the amount of time the patients require on Dialysis and this is causing delays for some patients who only require the minimum 4 hours. The Scottish Ambulance Service transports the Bute Patients and so they all have to wait until everyone has finished Dialysing before returning home. This is currently causing some difficulties as one patient requires 6 hours of dialysis when the other only require 4, causing delays for the others. Patients on Bute have concerns around the reliance on a Ferry to transport them for dialysis and again the length of days they have to endure to access treatment. One 80 year old patient described having to get up at 6am to prepare

for the journey and early pick up to the Ferry which exacerbates her health conditions and impacts on her well being. The Journey last 1 hour 30 minutes to travel from Bute to Inverclyde Hospital.

The issue within A&B HSCP is that patient demand for dialysis is spread across the whole area which makes it difficult to equitably locate a dialysis unit. Campbeltown was chosen for the pilot due to the patients having the furthest distance to travel and the ongoing road conditions and difficulties they had faced accessing treatment.

The tables below demonstrate the prevalence of the requirement by year of patients within Argyll and Bute. These tables were provided by Public Health.

Table 2: Prevalence at 31st December of each year from SRR extracted in April 2016.

			Year					Total 2011-2015
		Modality	2011	2012	2013	2014	2015	
Argyll & Bute HSCP	Overall	PD	10	7	6	4	7	**34**
		Home HD	0	0	0	0	0	**0**
		HHD	20	18	23	23	19	**103**
		Tx	44	41	43	49	50	**227**
		Un-assigned	0	3	0	0	0	**3**
		all above	**74**	**69**	**72**	**76**	**76**	**367**
	Bute & Cowal	all modalities	*21*	*20*	*23*	*25*	*24*	***113***
	H&L	all modalities	*18*	*18*	*16*	*18*	*16*	***86***
	MAKI	all modalities	*15*	*14*	*18*	*16*	*18*	***81***
	OLI	all modalities	*20*	*17*	*15*	*17*	*18*	***87***

Table 3: Incidence of new patients taking up RRT per calendar year by age group.

		Year					2011-2015	
	Age range	2011	2012	2013	2014	2015	no	%
A & B HSCP	Under 18	2	0	1	0	0	3	7%
	18-44	0	0	0	2	3	5	12%
	45-64	1	3	3	3	3	13	30%
	65-74	5	3	3	2	2	15	35%
	75 and over	3	1	3	0	0	7	16%
	All ages	**11**	**7**	**10**	**7**	**8**	43	100%

Table 4: Incidence of new patients taking up RRT per calendar year by Locality

	Year					2011-2015	
	2011	2012	2013	2014	2015	**no**	**%**
B&C	1	3	4	2	2	**12**	**28%**
H&L	3	2	0	2	2	**9**	**21%**
MKI	4	1	6	1	3	**15**	**35%**
OLI	3	1	0	2	1	**7**	**16%**
A & B HSCP	**11**	**7**	**10**	**7**	**8**	**43**	**100%**

Table 5: Incidence (number per year) of transplants undertaken

	2011	2012	2013	2014	2015	2011-2015
Argyll & Bute HSCP	4	1	3	2	4	**14**
Inner Moray Firth Unit	2	8	8	8	6	**32**
North & West Unit	0	0	3	3	3	**9**
Highland HSCP	2	8	11	11	9	**41**
unmapped	0	0	1	1	0	**2**
NHS Highland	**6**	**9**	**15**	**14**	**13**	**57**

Further projections on the future prevalence for dialysis are expected from Public Health but unfortunately have not been available by the time this report was to be submitted. These projections would be taken into consideration if the IJB agreed to further scoping work in other localities. .

6.2 Accessibility

Patient travel to and from hospital is the main source of complaint of hospital HD patients especially within A&B.

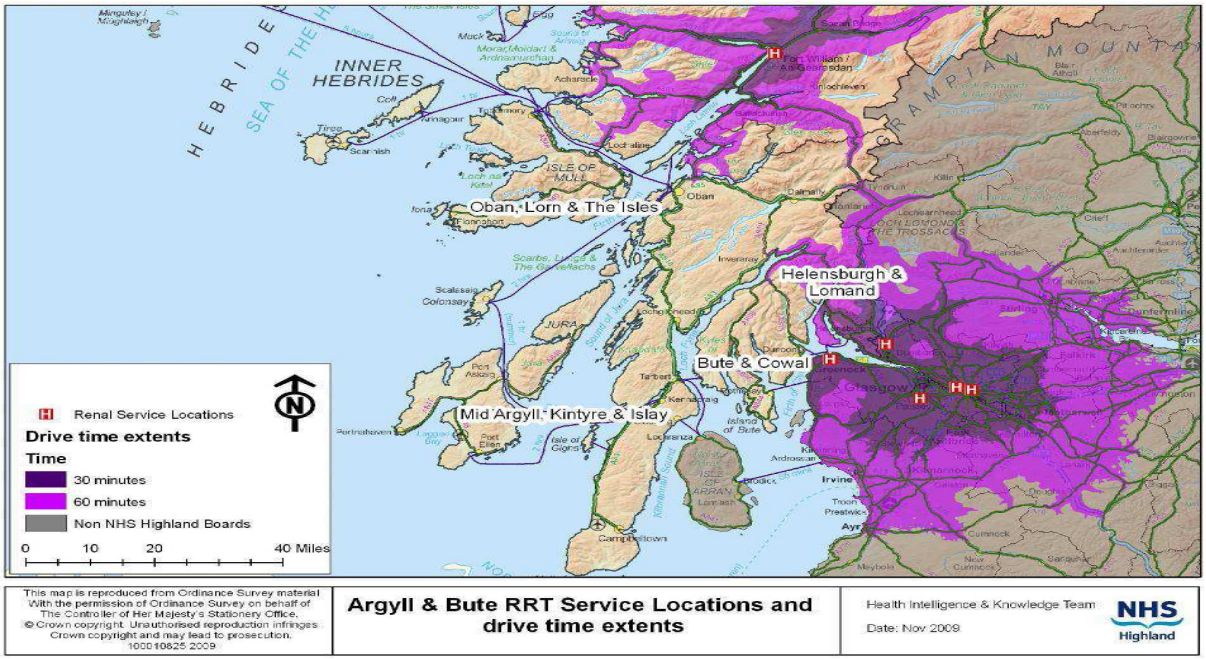
Unfortunately due to the Remote and Rural geography of Argyll and Bute, Dialysis patients are forced to undertake significant journeys 3 times per week to access dialysis treatment. The HSCP has followed best practice in that it has provided specialised, fully funded transport for dialysis patients, which is the recommended gold standard, and this tries to facilitate timely transport by car or ambulance to meet patient guidelines.

However, for patients on dialysis treatment within A&B their dialysis days are long and tiring as they include many hours travelling to hospital, treatment times which last for 4-5 hours a session, recovery time and then travelling home. This takes up most of the day for three days each week.

"Loss of time, freedom and the restriction caused by regular hospital treatment are the top complaints of dialysis patients," says Tim Statham of the National Kidney Federation (NKF).

Considering the rural geography of Argyll & Bute and the reliance on delivering dialysis out-of-area, prior to the Kintyre pilot, all dialysis patients would have travelled for considerably longer periods of time than the UK averages. Therefore based on an international study, carried out in 2008 examined the Health Related Quality of Life for dialysis patients in A&B would have a higher relative risk profile. (***Moist LM et al, American Journal of Kidney Diseases 2008 51(4): 641-50)***

Below is a map of the Argyll and Bute which demonstrates the accessibility difficulties faces by A&B patients who require access to Glasgow hospitals for dialysis.



6.3 Assessment

The success of the Campbeltown pilot has shown that local dialysis to this level can be provided in Argyll and Bute. It is also clear that providing additional units in other hospital sites will incur significant capital and revenue costs and will require a similar level of commitment from the nursing staff and NHSGG&C clinical support.

To allow a thorough analysis /viability report for each area, it would be useful to look in more detail with Locality Planning Groups in particularly Oban and Bute around their local priorities whilst also considering at a macro level the development of such units would not be seen as a priority due to the Quality and Financial Plans and the Strategic Plan for the next 2 years. However it is important that an assessment is considered and if necessary conducted by the Locality Planning Groups facilitated by the planning department.

The SMT has considered this and has also acknowledged that communities on Bute and Oban area have expressed interest and support in fund raising for a local dialysis facility. The Bute community have already started fundraising therefore it is recommended that scoping work is undertaken to assess the viability of a Unit on Bute in the first instance. In addition, Bute currently has the greatest amount of patients travelling for this treatment.

There will be a need to present/share these findings and conclusion with the respective stakeholders and communities and it is recommended that this paper is shared with these groups accordingly.

7 GOVERNANCE IMPLICATIONS

Financial Impact

7.1 The evaluation of the unit has demonstrated that the revenue costs of staffing and running the unit can be met from the reduction in costs due to travel for patients.

7.2 The generous support of the community and BKF covered the capital and staff training costs of the unit, without which the unit could not of been built or operated. There

remains an outstanding equipment cost to be funded regarding the dialysis machines and chairs. The Campbeltown dialysis community group will be approached to fund this, but it is also likely the HSCP may have to find this funding.

7.3 The unit is operating under capacity at the present time, the opportunity to expand the catchment area and offer holiday dialysis would also enhance its cost efficiency.

Staff Governance

7.4 The nursing staff have been fully to undertake this role in both capacity and capability.

Clinical Governance

7.5 Significant clinical governance issues were identified to establish the unit. These have all been addressed within the pilot and ongoing arrangements are in place to ensure standards, patient safety and contingency are in place.

Equality and Diversity Implications

7.6 The local dialysis unit has addressed the inequity issues of access for this community which had the longest travel time to access hospital dialysis

Public & User Involvement and

7.7 The pilot involved extensive engagement with the local community and the users of the service to ensure local needs and requirements shaped service provision. This has also informed the feedback from patients.

Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Agenda item : 5.9

Date of Meeting : **30 November 2016**

Title of Report : **Annual Report of the Chief Social Work Officer 2015/16**

Presented by : **Louise Long**

The Integration Joint Board is asked to :

- **Note** the Chief Social Work Officer Annual Report 2015/16
- **Note** that new statutory guidance on the role of the Chief Social Work Officer has been published by the Scottish Government

1. EXECUTIVE SUMMARY

The report summarises the Chief Social Work Officer Annual Report covering the period 1 April 2015 – 31 March 2016.Local authorities are required, under Section 3 (1) of the Social Work (Scotland) Act 1968 as amended, to appoint a Chief Social Work Officer (CSWO). The CSWO's responsibilities contained within the Council's Scheme of Delegation and Administration.

Each year CSWO is required to submit a report to Scottish Government to support the Scottish Governments Chief Social Worker Advisor in his role in promoting and reporting on social work matters, and to provide benchmarking and good practice information that could be shared across Scotland. The report was submitted to Scottish Government on 31st September.

The CSWO report for Argyll & Bute sets out the activity of the social work service, the report is a collaboration between CSWO, Head of Service – Adult Care East. The report details all social work, the format has been changed this year to provide more detail, to give the council and the public more information about social work services. 2015/16 has been a year of unprecedented change for social work, Health & Social Care.

2. INTRODUCTION

The report summarises the Chief Social Work Officer Annual Report covering the period 1 April 2015 – 31 March 2016. Local authorities are required, under Section 3 (1) of the

Social Work (Scotland) Act 1968 as amended, to appoint a Chief Social Work Officer (CSWO). The CSWO's responsibilities contained within the Council's Scheme of Delegation and Administration.

Each year the CSWO is required to submit a report to Scottish Government to support the Scottish Governments Chief Social Worker Advisor in their role in promoting and reporting on social work matters, and to provide benchmarking and good practice information that could be shared across Scotland. The report was submitted to Scottish Government on 31st September after council approved the contents.

2015/16 has seen the most significant change in Social Work in respect of policy and governance since the introduction of the Social Work (Scotland) Act 1968. Despite the considerable changes in governance, structure and organisational arrangements this year to prepare for Health and Social Care integration, staff have continued to work together to deliver improvements. It is indeed credit to our dedicated workforce that they have continued to deliver improvement in a period of considerable change.

The Joint Inspection of Older People's Services took place in 2015 and a positive inspection report was delivered. The partnerships have been working on a series of improvement actions to address eleven recommendations made with areas of strength and improvements identified through grading of seven adequate and two goods.

3. DETAIL OF REPORT

The CSWO is required to ensure the provision of appropriate professional advice in the discharge of local authorities' statutory duties. Overall, the role is to provide professional governance, leadership and accountability for the delivery of Social Work services whether these are provided or purchased from voluntary and private sector. In addition there are a small number of specific duties and final decisions with Adult with Incapacity, Looked after Children and Secure Accommodation which must be made by the CSWO.

In March 2009, the Scottish Government issued national guidance on the role and function of the Chief Social Work Officer (The Role of the Chief Social Work Officer: Principles, Requirements and Guidance pursuant to Section5 (1) of the Social Work (Scotland) Act 1968). This guidance has recently been reviewed and revised statutory guidance has recently been published. This has also been considered in developing a Clinical Care Governance Framework agreed by the Integrated Joint Board. The guidance is available to IJB members for information.

The CSWO Annual Report 2015/16 (Appendix 1) provides an overview of the performance and delivery of social work and social care services in Argyll and Bute. It also provides an overview of the specific activities of the CSWO in respect of professional leadership and decision making.

3.1 CONTEXT

In 2015/16 Argyll and Bute's Integration Joint Board (IJB) formally agreed to adopt the Integration Scheme and the Argyll and Bute's Health and Social Care Partnership 3 year Strategic Plan. This included delegated powers in relation to all local authority social work services, including children and families, justice and adult services. The early year's which had been with children and families social work within the local authority has moved to Education, and is now delivered through the Community Services Directorate.

Integrated Joint Board (IJB) had a shadow period and went live on 2nd April 2016. It is supported by an Audit Committee and Clinical Care Governance Committee. The

Argyll and Bute Health and Social Care Strategic Plan 2015/16 was approved on 23rd March and sets out the key priorities for health and social care in Argyll and Bute. To support these local arrangements early work has been undertaken in defining localities across Argyll and Bute. Nine locality groups have been established to support the delivery through "Locality Planned, Owned and Delivered"

4. CONTRIBUTION TO STRATEGIC PRIORITIES

The CSWO is a member of the Health and Social Care Partnership Management Team. In 2015/16 the former social work management team was replaced by a new integrated management team. The CSWO has continued to meet with senior social work qualified staff. There is an emerging gap with all managers with responsibility for delivering health and social care requiring to understand the unique professional issues and challenges within social work and social care. This has led to the development of a Social Work Leadership Forum which has oversight of professional practice, reporting to the Senior Management Team and, where appropriate, the Clinical and Care Governance Committee within the Health and Social Care Partnership. A development program with senior managers from HSCP is taking place across 2015/16 to improve confidence and competence within all areas of health and social care.

In respect of public protection, the CSWO has oversight of all public protection matters, enabling advice to be given to the Chief Executive in his role as Chair of the Chief Officer's Public Protection Group. The CSWO attends the Child Protection Committee; Adult Protection Committee; Violence Against Women Partnership; Alcohol and Drugs Partnership and MAPPA Strategic Oversight Group. The arrangements are currently being reviewed to ensure appropriate governance is available to the Chief Executive.

The CSWO is a member of the Integrated Joint Board (IJB) and during the first year of implementation in 2015/16, opportunities have been taken to present reports and to highlight the work taking place across social work and social care. Given that many IJB members and participants stem from health backgrounds, the social work functions relating to adult care and health has been central to consideration of shifting the balance of care. The statutory work relating to children and families and criminal justice social work services is less familiar, and more time is needed to ensure that the holistic nature of social work provision is fully understood and recognised.

The CSWO is a member of Argyll and Bute's Health and Social Care Clinical and Care Governance Committee and led with the Lead Nurse in the development of Clinical and Care Governance Framework to ensure safe governance accountability and practice in place across the partnership.

Arrangements are in place for designated senior managers with appropriate social work qualification and skills to deputise for the CSWO in her absence, ensuring appropriate cover, while also creating learning and experiential opportunities for senior staff.

The CSWO continues to be responsible for certain statutory decision making relating to vulnerable children and adults. In addition the CSWO is currently also the agency decision maker in respect of adoption and fostering decisions. All aspects of the CSWO role are detailed within the report.

4.1 HIGHLIGHTS AND FUTURE PRIORITES

The CSWO Annual Report 2015/2016 sets out a summary of the work taking place across social work and social care services in Argyll and Bute. It is comprehensive and captures the significant activity undertaken across social work. This includes:

- Positive Inspection for Joint Older people services
- Improving record of delayed hospital discharges throughout 2015/16
- Improving identification and support to vulnerable adults and children with protection process
- Improvement in finding 'Forever Families' for children unable to stay with their birth parents
- The service demand was 584K for 2015/16 reducing to 527K 2016/17 onwards for kinship used to support Kinship carers
- 45% reduction in referral from SCRA on youth offending
- Early identification and support to parents through development of local parenting support
- Highly successfully corporate parenting board who have attracted additional funding, supported the building of a new children house, very good grades across all children houses in Argyll and Bute
- 15,452 unpaid work scheme (using the average national wage) this equates to £98,893 of labour through Criminal Justice service

4.2 FUTURE PRIORTIES

- The smooth transition from Criminal Justice Authorities to Community Planning Partners for responsibility for Community Justice
- The implementation of Children and Young People Act and new statutory duties
- The implementation of new Carer Act and new statutory duties
- The revised Autism Strategy and Plan
- The redesign of service to support outcomes with 3 year HSCP strategic plan
- Meeting zero target for delay discharge
- Reshaping service for older people to allow people to stay at home wherever possible

5. GOVERNANCE IMPLICATIONS

5.1 Financial Impact

There are no financial implications associated with this report

5.2 Staff Governance

There are no human resources implications associated with this report.

5.3 Clinical Governance

There are no clinical governance implications associated with this report

6. EQUALITY & DIVERSITY IMPLICATIONS

There are no equality implication associated with this report.

7. RISK ASSESSMENT

There are no specific risks associated with this report. The risks presented by the social work service are considered and managed through the Argyll and Bute Health and Social Care Partnership Risk Register and the Corporate Risk Register.

8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

Public views on Social work and Social care services are contained within the body of CSWO report.

9. CONCLUSIONS

In summary, a range of governance arrangements recognise the role and contribution of the CSWO in Argyll and Bute. In considering existing arrangements against the guidance on the role of the CSWO, and in the context of the new integrated structures, these arrangements will be further strengthened.

The report outlines significant activity of Social Work services across Argyll and Bute, the many successes and the dedicated workforce who continue to deliver services on behalf of Argyll and Bute Council and The Health and Social Care Partnership.

Argyll and Bute Council

Chief Social Work Officer

Annual Report

2015/16

Louise Long
Head of Service – Children & Families and Criminal Justice
Chief Social Work Officer
July 2016

1. Introduction

Every day Social Services deliver essential support to some of our most vulnerable people in Argyll and Bute. This support is wide ranging and encompasses services delivered by statutory and private organisations. Services are provided for people at all steps of life and in all kinds of circumstances. Social Work also assess and manage risk and provides public protection by intervening to protect and support our vulnerable people.

The British Association of Social Work's vision clearly articulates the purpose of the Social Work Service:

'Social Work is a practice based profession and an academic discipline that promotes social change. Principles of social justice, human rights, collective responsibility and respect for diversities are central to Social Work'

The vision stresses the unique contribution Social Services make to our communities. It is one of the few services delivered by Argyll and Bute Council 24 hours a day, 7 days per week. Staff work tirelessly within a changing policy landscape to deliver good quality services that identify, support and protect. As a Council and a community we have a responsibility to our most vulnerable, a responsibility that is held individually and collectively. Social Work services are delivered on the Council's behalf by a skilled and valued workforce who work to empower, support and protect.

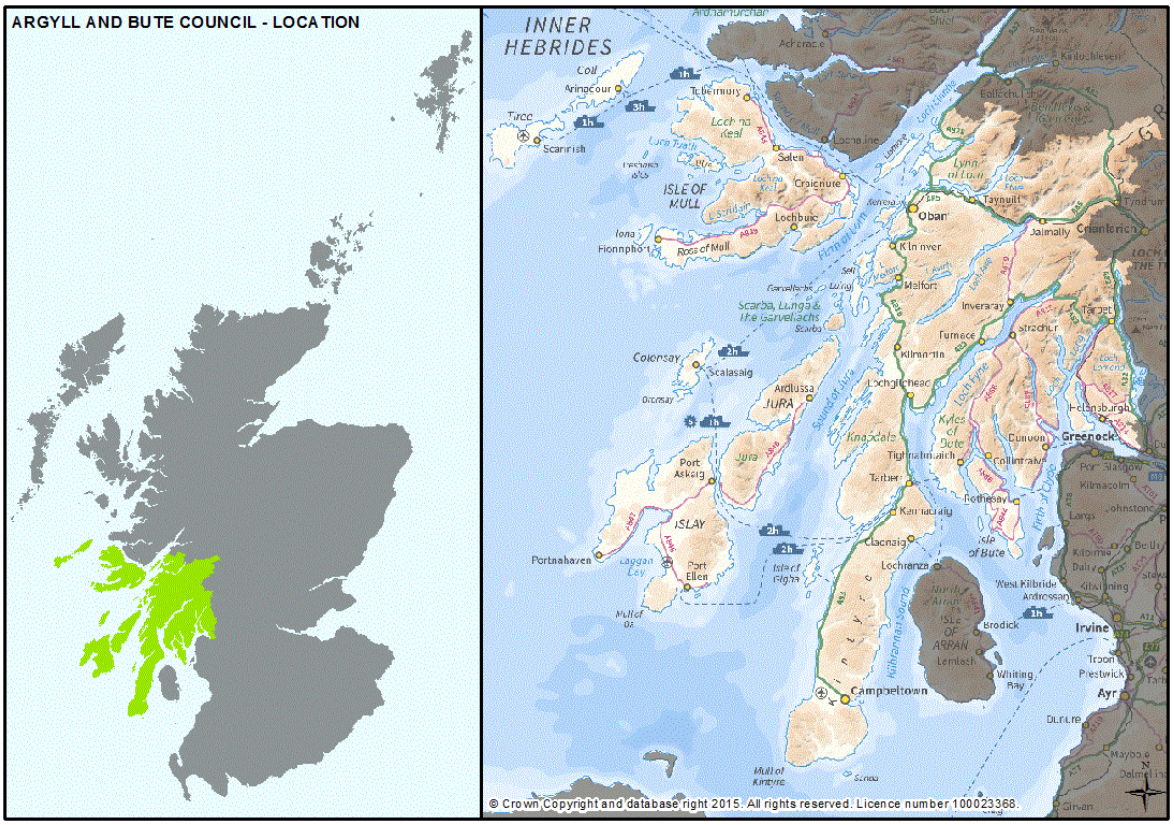
This year's report is written within increasing demands and expectations, new legislation both national and local policy drivers impacting on Social Services to deliver more with less. Significant developments in Health and Social Care Integration, new powers and duties in respect of the Children and Young People's Act, the Carer's Act and preparations for major changes in Criminal Justice Services have been the focus for this year's work.

This level of change is unprecedented and whilst we have a great opportunity to change how we deliver and improve outcomes, we all need to be alert to our ongoing responsibility for Social Work services.

Despite the considerable changes in governance, structure and organisations arrangements this year to prepare for Health and Social Care integration this year, staff have continued to work together to deliver improvements. It is indeed credit to our dedicated workforce that they have continued to deliver improvement in a period of considerable change.

In Argyll and Bute, Social Work services have played a central role in managing Early Year's services. In 2015 the Early Years' Service moved to Education, however the strong leadership and partnership working will continue to deliver early identification and support to families

The Joint Inspection of Older People's Services took place in 2015 and a positive inspection report was delivered. With areas of strengths and improvement identified through the grading of seven adequate and two goods. The partnership has been working on a series of improvement actions to address the eleven recommendations made.



Argyll and Bute is the second largest local authority by area in Scotland, after Highland. The authority covers a land area of 690,947 hectares, Argyll and Bute has the third sparsest population (averaging just 13 persons per square kilometre) of Scotland's 32 local authorities (Census 2011).

The landscape is characterised by long sea and freshwater lochs, peninsulas and islands. The physical geography of the area adds considerably to the journey times between settlements and communities. The limited road network makes the area vulnerable to disruption, and diversions tend to be long. Island communities are vulnerable to ferry disruptions, particularly in the winter months.

Argyll and Bute has 23 inhabited islands, more than any other Scottish local authority. These are: Bute; Coll; Colonsay; Danna; Easdale; Eilean da Mheinn; Erraid; Gigha; Gometra; Inchtavannach; Innischonan; Iona; Islay; Jura; Kerrera; Lismore; Luing; Mull; Oronsay; Seil; Shuna (Luing); Tiree; Ulva (Census 2011).

- Helensburgh and Lomond
- Mid Argyll, Kintyre and Islay
- Oban, Lorn and the Isles
- Bute and Cowal

1.1 Population

Argyll and Bute has a total population of 86,890 .The population profile for Helensburgh and Lomond is younger than for the other three Administrative Areas. Nonetheless, the

population of Helensburgh and Lomond, in common with populations across the rest of Argyll and Bute, is ageing.

The population projections for Argyll and Bute indicate a gradual and sustained reduction in the number of children and young people aged 0-16 and an increasing population of older people over a projection period between 2012 to 2037.

Table 1: Projected population for Argyll and Bute, compared to NRS 2014 Mid-Year Estimate

			NRS 2012-based population projections				
Age cohort	**Base year 2012**	**MYE 2015**	**2015**	**2020**	**2030**	**2037**	**%change within cohort (2012-2037)**
0-15	14,069	13,292	13,259	12,806	12,173	11,488	-18%
16-24	8,260	8,705	8,347	7,368	6,264	5,870	-29%
25-44	19,726	17,280	16,670	16,122	15,846	14,842	-25%
45-64	26,490	26,289	25,807	24,277	18,838	16,261	-39%
65-74	11,328	12,020	11,958	12,161	12,197	11,474	1%
75+	8,827	9,304	9,469	10,797	13,896	15,248	73%

(Sources: NRS 2012-based population projection (principal projection); NRS 2015 Mid-Year Estimates)

The NRS 2012-based projections highlight the demographic challenge facing Argyll and Bute. If current trends continue, absolute numbers and proportions of older people will increase as numbers and proportions of people in younger age cohorts will fall.

1.2 Economy

Argyll and Bute's economy is predominantly service-based. 85.9% of employee jobs in the area are provided within the service sector (ONS Business Register and Employment Survey 2014). Argyll and Bute has relatively high levels of employment in accommodation and food services, and low levels of employment in manufacturing and finance. The proportion of employee jobs within the public sector is higher in Argyll and Bute than the national average.

Unemployment rates in Argyll and Bute are below the Scottish average although, because of the high levels of seasonal employment in the area, rates vary according to time of year. Gross Value Added (GVA) figures show that Argyll and Bute's economy is performing less strongly that the Scottish average.

The Faslane naval base is the largest single site employer in Scotland. The MOD directly employs some 4,750 people in Argyll and Bute (3,390 military personnel and 1,360 civilians) (MOD, Quarterly location statistics: 1 April 2016). The age profile of the military personnel lowers the average age of the population in Helensburgh and Lomond, and produces a noticeable bulge in younger working-age male cohorts in the area.

1.3 Deprivation

The SIMD 2012, produced by the Scottish Government, identifies small-area concentrations of multiple deprivation across Scotland. The SIMD is produced at datazone level, with datazones being ranked from 1 (most deprived) to 6,505 (least deprived).

According to SIMD 2012, the most recent version of the index, 10 datazones within Argyll and Bute were in the 15% most overall deprived datazones in Scotland.

These ten datazones are located in Argyll and Bute's main towns:

- Two each in Helensburgh, Rothesay and Campbeltown
- Three in Dunoon
- One in Oban

The SIMD identifies concentrations of deprivation. Because the SIMD identifies concentrations of deprivation, smaller pockets and instances of individual deprivation are not picked up by the index. Deprivation can, and does, occur outside of the most deprived data zones.

Patterns of deprivation vary by deprivation domain. A particular contrast can be seen between levels of access deprivation, which affects most of rural Argyll and Bute and levels of deprivation across other SIMD domains, which show higher levels of deprivation in the towns.

2. Community Planning Partnership

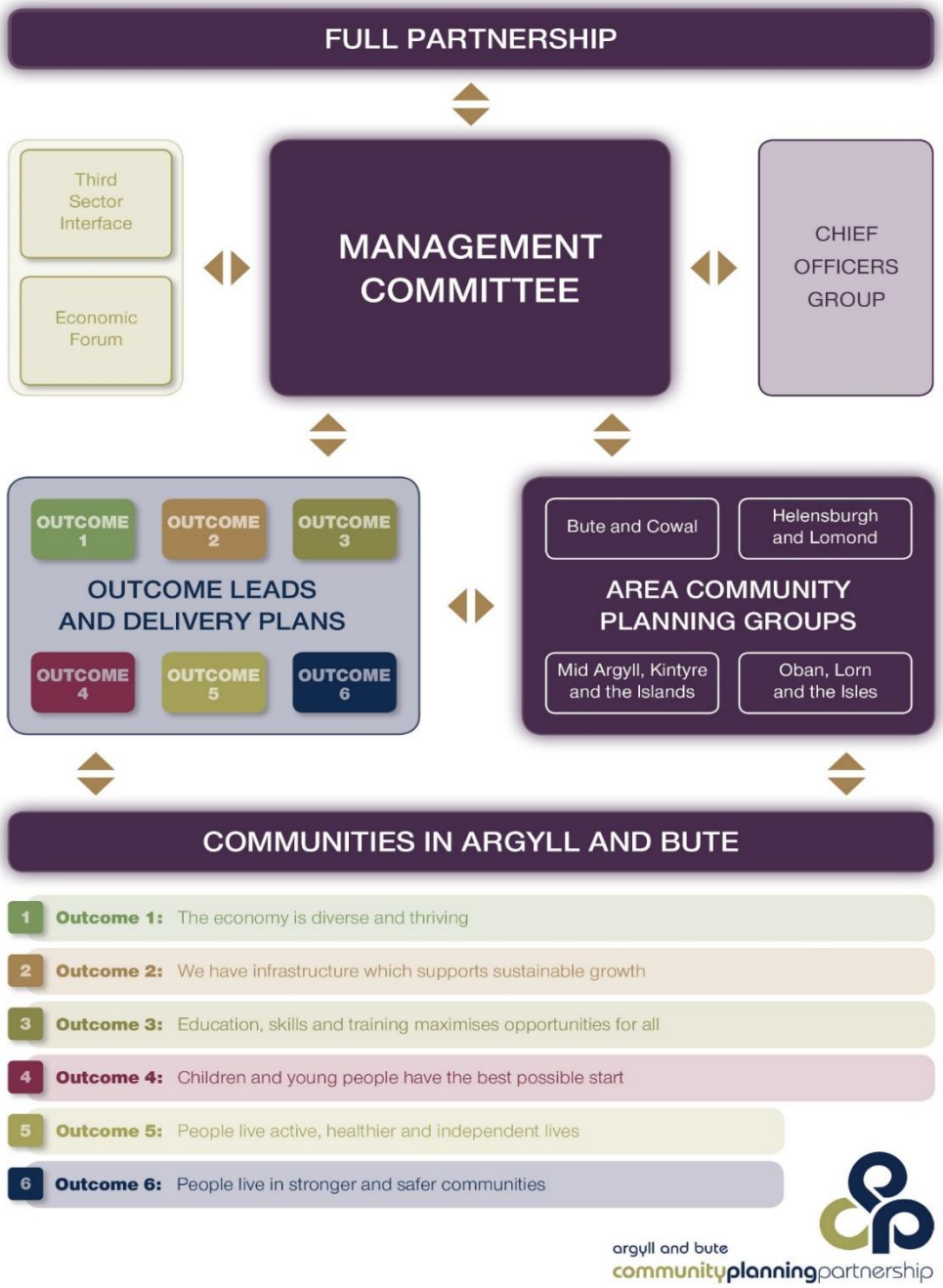
The Argyll and Bute Community Planning Partnership is designed to provide strong multi-agency leadership in order to deliver the best possible outcome for the people of Argyll and Bute.

The Partnership is supported to deliver outcomes by six outcome delivery groups which take forward the key strategic priorities of the partnership.

The Outcome Delivery Groups are given direction, challenge and support from the Community Planning Partnership Management Committee which provides the key link between strategy and delivery of local outcomes for our communities. Four Area Community Planning Groups consider local issues of relevance to the outcome of the Partnership and feedback on these to both the Outcome Delivery Groups and the Management Committee through regular agenda items at each.

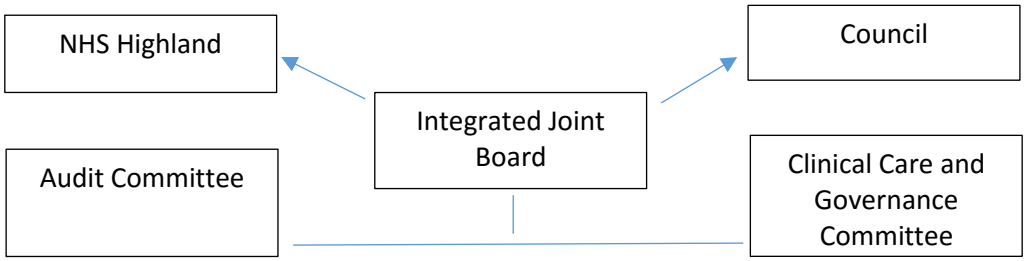
The CPP has a Full Partnership Board this meets annually and considers overall progress and direction.

Community Planning Partnership



2.1 Strategic Implications

As well as the corporate plan, single outcome agreement (now known as LOIP) the 3 year strategic plan for the HSCP has been developed across 15/16 in preparation for integration. A new integrated management structure has been put in place as well as a new governance structure. From 1st April the structure will be:



3. Health and Social Care Partnership

In 2015/16 shadow board for Integrated Joint Board was established and an integrated management structure created. On 1st April the Argyll & Bute HSCP has set out an ambition to implement "Locality Planned, Owned and Delivered" arrangements which will:

- Understand health and care needs of our communities
- Bring together partners to plan within a strategic framework to meet needs and achieve national outcomes
- Organise and deliver services in local areas which are integrated of high quality, safe, appropriate, sustainable and continually improving.
- Operate within budgets, complying with care, workforce, and audit standards
- Manage performance ensuring this is informed by service user and public involvement and feedback
- Be the local focus for service delivery and support to the population or communities within the area concerned.

To support these local arrangements early work has been undertaken in defining localities across Argyll and Bute, based on the 2011 data-zones with a correction for Colonsay. The eight localities are identified as:

HSCP locality	**Areas covered**
Bute	Isle of Bute
Cowal	Lochgoilhead, Strachur, Tighnabruaich, Dunoon
Helensburgh and Lomond	All Helensburgh & Lomond
Mid-Argyll	Tarbert, Lochgilphead, Ardfern, Inveraray,
Kintyre	Southend, Campbeltown, Muasdale, Carradale (including Gigha)
Islay and Jura	Isles of Islay and Jura
Oban, Lorn	Easdale to Oban, to Port Appin to Dalmally, Lismore and Kerrera
Mull, Iona, Coll, Tiree and Colonsay	The Isles of Mull, Iona, Coll, Tiree and Colonsay

3.1 Partnership Structure/Governance Arrangement

The CSWO is required to ensure the provision of appropriate professional advice in the discharge of local authorities' statutory duties. Overall, the role is to provide professional governance, leadership and accountability for the delivery of Social Work services whether these are provided or purchased from voluntary and private sector. In addition there are a small number of specific duties and final decision such as Adult with Incapacity, Looked after Children and Secure Accommodation which must be made by the CSWO.

CSWO has clear lines of accountability and reported to Executive Director of Community Services and now the Chief Officer of the Health and Social Care Partnership. During 2015/16 the CSWO met regularly with the Executive Director of Community Services to discuss policy, strategic development, workforce development and complex operational issues. The Head of Adult Care (East) deputises for the CSWO. In addition there are regular scheduled meetings with the Chief Executive and Heads of Service to ensure the Chief Executive is advised of any matters in respect to the statutory functions of social work.

The CSWO has the responsibility to directly advise Council on any areas that she feels may be significant risks to Argyll and Bute. Elected members leadership and governance of SWS is divided between, Community Service Committee, Audit Committee, Performance Scrutiny Committee. In April 2016 this moved to the Integration Joint Board.

In respect of Public Bodies Act, the CSWO has played a role in developing the integration scheme including the development of new Clinical Care Governance arrangements to ensure appropriate mechanisms are in place to support safe, client centred practise. The CSWO has had a lead role in the development of the Clinical Care Governance framework which provides governance and reassurance to the Integrated Joint Board. The CSWO is a professional adviser to the Integrated Joint Board.

3.2 Specific Decisions by the CSWO

Across 2015/16 in addition to chairing level 3 MAPPA, the CSWO is the legal guardian for 48 people within Argyll and Bute. The CSWO has made specific decisions on behalf of the Council in respect of following:

- 2 Secure accommodations
- 12 Permanence Orders
- 4 Adoption Allowance
- 5 Permanent foster carers
- 4 Temporary foster carers
- 4 Kinship carers
- 4 Prospective adopters
- 8 Carer removal (retirements, move to adoptive carers)
- 22 Variations to Compulsory Supervision Orders for Looked after Children to be moved

There has been ongoing recruitment of foster carers to provide placements for Looked After Children. The number of foster carers moving to permanently caring for children has increased.

3.3 Welfare Guardianship Orders

Mental Welfare Commissions guidance on Deprivation of Liberty using 13ZA has contributed to an increase of private applications. The rise has created pressures within the Community Mental Health Team as each order requires the input of Mental Health Officer (MHO) however this has been managed within the current resource. In 2015/16 there has been 14 new guardianships granted

4. Finance

There is a history of good strong financial management within the Social Work service. However, it is a needs-led service and there is always potential for volatility. Across the Council all services have achieved 1% efficiency savings in 2015/16.

4.1 Adult Services

Adult Services demand for service continues to rise. A particular challenge is the over 75 population growing faster than anywhere else and this puts considerable pressure on elderly care budgets. In 2015/16 the overspend of £1m for Adult Services can be attributed to the high demand for homecare and external care home placements.

Argyll and Bute Council and NHS Highland used the 3 year Integrated Care Fund provided by the Scottish Government to reduce avoidable admissions to hospital, improve accelerate discharge from hospital, develop carers services and resilience in communities. In 2015/16 the reported emergency admission increased from 71,018 bed days to 77,924 bed days. It is important that the focus of the new Health and Social Care Partnership Strategic Plan focusses on ensuring that only sick people are in hospital.

4.2 Children and Families and Criminal Justice

Criminal Justice finance is ring fenced funding given through Community Justice Authorities. The finance formula is based on workload and takes no consideration of rurality. Criminal Justice is delivered in partnership with East and West Dumbarton. In 2015/16 the partnership was overspent by £147K with Argyll and Bute meeting 1/3rd of this at a cost of £47K. Year on year Criminal Justice services are overspent. To deliver a service in Argyll and Bute there is a minimum number of staff required to service the courts and ensure good public protection.

4.3 Children and Families

The financial impact of Children and Young People (Scotland) Act has seen significant increase in funding required to deliver on statutory duties within the Act. In October 2015 parity for kinship carer and foster carers was introduced so that kinship carers receive the

same support and financial compensation as foster carers. The Scottish Government and Council have provided financial support for kinship carers, while this financial assistance will meet needs initially it is unlikely to meet the demands associated with projected growth in this area. The financial impact of Part 10 and 11 of the Act will put pressure on the whole system to provide support to Looked After Children up to age 25. With increased costs of internal and external placements the amount allocated to the Council is unlikely to meet increasing costs over next 3 years.

Budget and Expenditure

Adult Services	**2013/2014**	**2014/2015**	**2015/2016**
Net Expenditure	£41,446,939	£42,962,573	£43,856,731
Children and Families and Criminal Justice	**2013/2014**	**2014/2015**	**2015/2016**
Net Expenditure	£11,564,637	£11,890,646	£13,359,272

Between 2014/15 to 2015/16 Argyll and Bute has increased expenditure on Adult Services by £894k

Between 2014/15 to 2015/16 Argyll and Bute has increased expenditure on Children and Families services by £1,469k, however £1,424k of this was a reallocation of the administrative resource from Adult Services to Children and Families.

Overall spend on net Social Work Service in Argyll and Bute as a proportion of net Council Services spend was 25%.

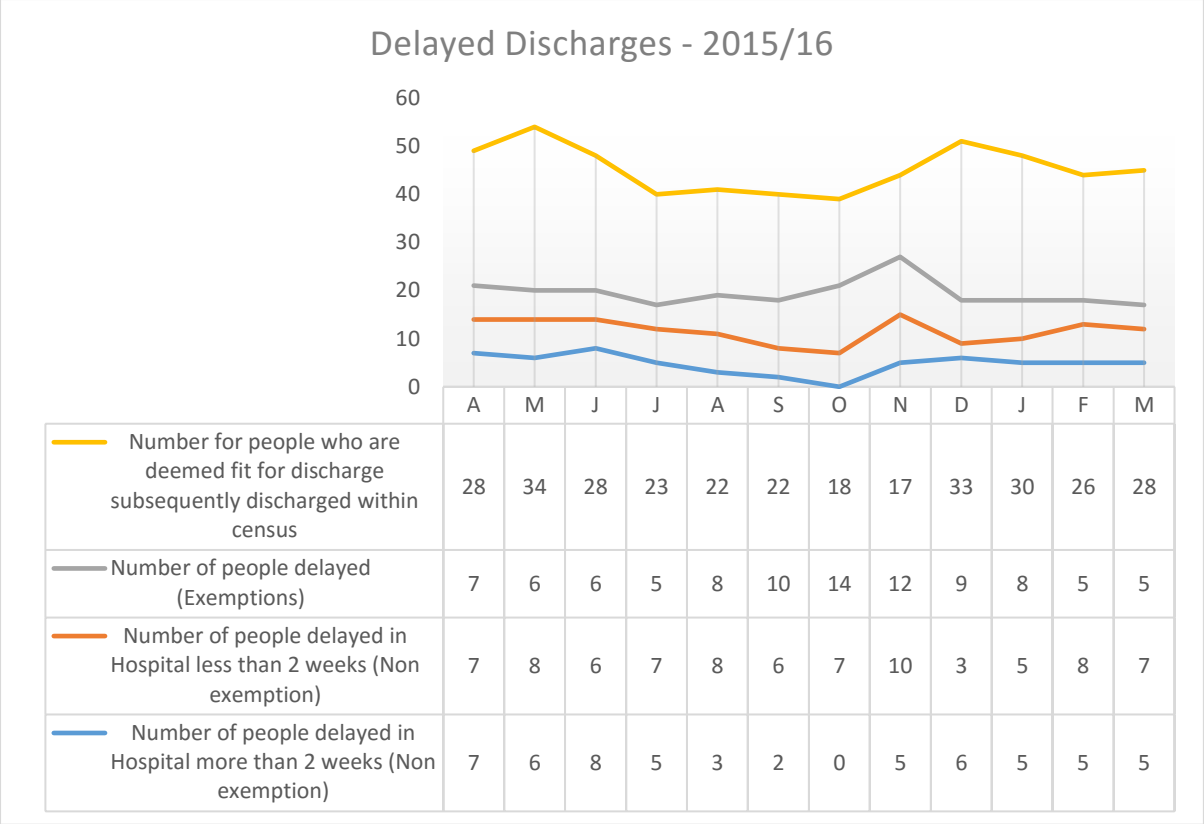
5. Services within Adult Care

There are 5 Area Team's delivering assessment and care planning across all vulnerable adult groups within Argyll and Bute. The teams focus is public protection for vulnerable groups and ensuring that those who can be cared for in the community are supported appropriately.

5.1 Delayed Discharges

Sustaining a high level of performance in Delayed Discharge at a time when the number and dependency levels of those service users coming through the system continues to increase while recruitment into home care and key NHS community posts becomes increasingly problematic.

Argyll and Bute Adult Care Services monitors the total number of delayed discharge adults within hospitals from Argyll and Bute Area who are medically fit for discharge. This includes Complex Needs Codes 9, 9/51X and 9/71X. As at March 2016, Argyll and Bute performed 18th out of the 32 Local Authorities.



	A	M	J	J	A	S	O	N	D	J	F	M
Number for people who are deemed fit for discharge subsequently discharged within census	28	34	28	23	22	22	18	17	33	30	26	28
Number of people delayed (Exemptions)	7	6	6	5	8	10	14	12	9	8	5	5
Number of people delayed in Hospital less than 2 weeks (Non exemption)	7	8	6	7	8	6	7	10	3	5	8	7
Number of people delayed in Hospital more than 2 weeks (Non exemption)	7	6	8	5	3	2	0	5	6	5	5	5

5.2 Care at Home

Argyll and Bute social work services have continued to support an increasing number of people to live at home, reporting year on year increases in the number of people aged 65+ directly receiving homecare. This peaked at 1097 in 2014/15, however the 2015/16 snapshot reported a slight decrease (7.1%) to 1019. This is associated with the success of our Re-ablement and Extended Community Care Team services, but does not indicate any reduction in demand for Care at Home Services. The proportion of care at home provision in terms of Personal Care remains significantly high.

The Number of Service Users awaiting a Homecare service has increase from 2 to 37 reflecting issues with care provision in certain areas within Argyll and Bute.

Homecare Data	**2013/14**		**2014/15**		**2015/16**	
Number of people aged 65+ receiving homecare	1,070		1,097		1,019	
Total volume of service Total No homecare hours per 1000 population aged 65+	10,650	540.9	10,726	520.2	10,357	490.6
No and % in receipt of : Personal care	1,064	99.1	1,066	97.2	1,001	98.2

5.3 Residential Care Home

In conjunction with supporting more people to live at home, social work services have focussed on managing a reduction in the number of people across the age groups, admitted to care homes. However, over the last three years the overall number of admissions has increased slightly from a total of 550 in 2013/14 to 566 in 2015/16, reflecting increasing demands for older peoples services in Argyll and Bute.

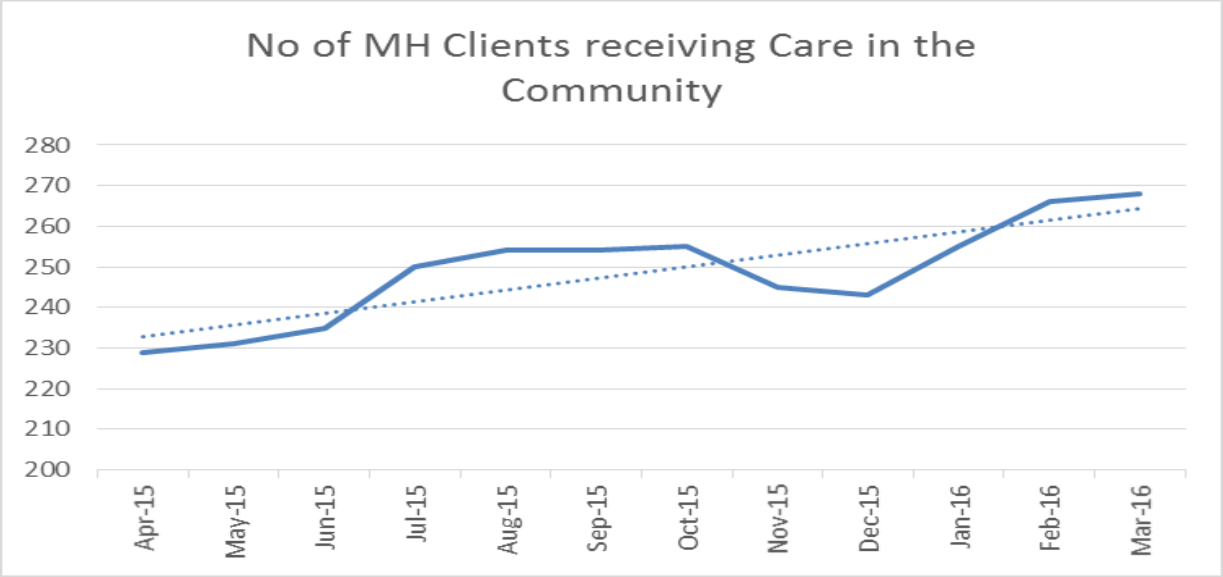
Care Homes	2013-14			2014-15			2015-16		
Number of Permanent / Long Stay Residents Supported in Care Homes	**18-64**	**65+**	**Total**	**18-64**	**65+**	**Total**	**18-64**	**65+**	**Total**
Older People	0	503	503	0	509	509	0	518	518
Physical Disability	2	0	2	1	0	1	1	0	1
Learning Disability	29	3	32	32	3	35	29	2	31
Mental health	2	1	3	1	1	2	3	1	4
Other	10	0	10	13	0	13	12	0	12
Total	**43**	**507**	**550**	**47**	**513**	**560**	**45**	**521**	**566**

5.4 Day Care Provision

Day Care is provided across localities using a traditional model of day care. People visit a central base and are provided with activities. The day care services are provided for older people and adults with learning disabilities. Older people's day care provision is currently under-utilised. The challenge moving forward is to re-design services and create more personalised approaches to care and support.

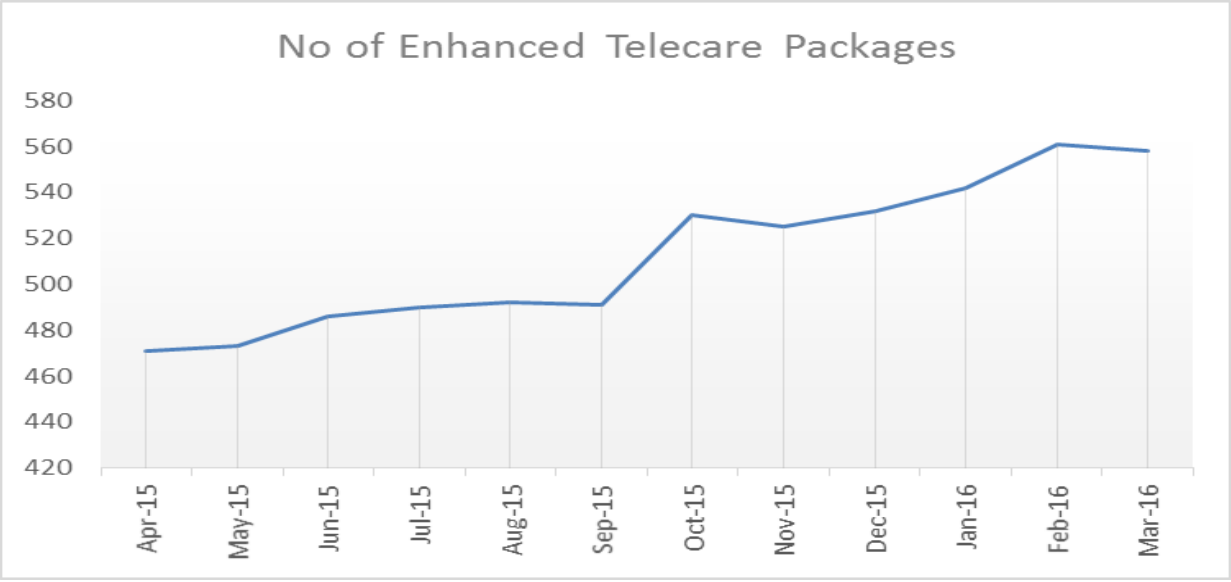
5.5 Mental Health Services

2015/16 has shown a sustained increase in the number of mental health service users being supported in the Community, increasing from 229 in April 2015 to 268 in March 2016 (an increase of 39 (17%)). This can be attributed mainly to the early co-location and integration of the MH health and community care teams and has been a positive model of collaborative working with Argyll and Bute.



5.6 No of Enhanced Telecare Packages

There has been a significant increase in the number of service users in receipt of Enhanced Telecare during 2015/16. Enhanced telecare packages offer a range of sensors, alerts and reminders that play a key role in enabling people to remain safely in their own homes and communities. Some packages can be remotely monitored via web-based technology, reassuring relatives or alerting professional carers to specific needs e.g. wandering.



5.7 Self-Directed Support

Self-directed Support (SDS) is about giving people more choice and control over how their support services are designed and making sure they receive support that meets their needs. It allows people to choose how their support is provided to them by giving them as much ongoing control as they want over the money spent on their support.

Direct Payments (DPs) are one of the ways of getting SDS. DPs have been around a lot longer – before SDS offered choice and control through other mechanisms. Our assessment staff continue to offer all the options under SDS legislation which includes access to direct payments for children, adults and older people.

5.8 Drug and Alcohol Services

In November 2015 Argyll and Bute Alcohol and Drug Partnership (ADP) became the first ADP in Scotland to engage an Independent Chair. This approach is being watched closely by both the Scottish Government ADP Support Team and other ADPs across Scotland who are considering following a similar model. Within the first six months of the engagement of the Independent Chair the ADP has undergone significant change in their structure and process. This has allowed an opportunity for a widening of engagement with service deliverers, service users and families.

Within the last year the ADP has started a number of key strategic reviews in partnership with National Drug and Alcohol Agencies. Central to this the ADP has taken the opportunity to look internally and tackle some of the partnership's persistent issues. Working alongside Scottish Recovery Consortium the ADP has acknowledged some of the key barriers to effective partnership and begun the lengthy process of overcoming these.

The Scottish Drugs Forum (SDF) have worked closely with the ADP partners on the first stages of developing a Recovery Oriented System of Care (ROSC). When completed this will establish a clearly understood partnership pathway which ensures all drug and alcohol service users are provided with services within a structure where these services communicate and service users can be supported on their recovery journey by which ever services best support their specific needs.

The ADP has also brought in Scottish Families Affected by Alcohol and Drugs (SFAD to undertake a first stage review of young people's drug and alcohol services in Argyll and Bute. This review was supported by Children and Families Services, the Education Department and Youth Services as well as a wide range of independent and third sector services deliverers across Argyll and Bute. The resulting report will form part of a wider service planning process for young people's drug and alcohol services in Argyll and Bute.

In addition to the above work the ADP has also engaged Figure 8 Consultancy Services to undertake a consultation with service users and their families with a view to establishing both Service User and Family engagement processes. When complete this will ensure that the people at the centre of the ADP's delivery strategy are those who the ADP are aiming to support.

ADACTION began delivering services across Argyll and Bute to those with a substance misuse issue, this is a commissioned service from the Alcohol and Drug Partnership.

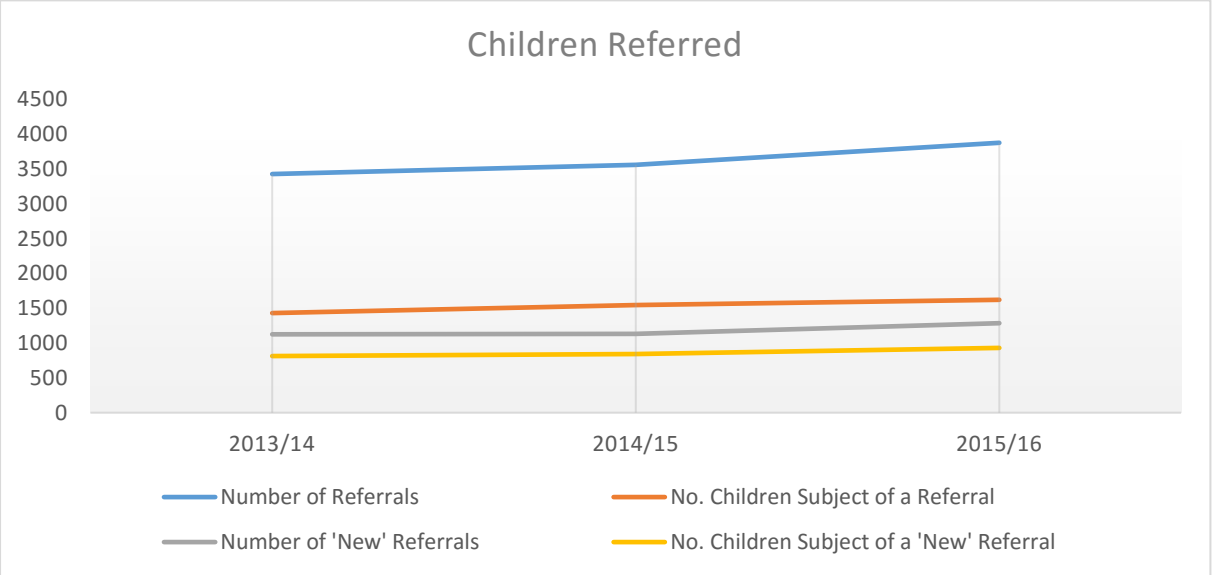
6. Children and Families

The number of children and families supported by Social Work continues to steadily increase with the number of looked after children and child protection, kinship placements activity.

Argyll and Bute is in contact with almost all its care leavers. This can be attributed to our excellent throughcare team who provide support to our young people. The £171,000 provided to support continuing care is being used to develop and enhance staffing to support ex care leavers. However there is a significant risk that this funding will not meet the needs in the three next years and the implications will need to be considered by the Integrated Joint Board and the Council.

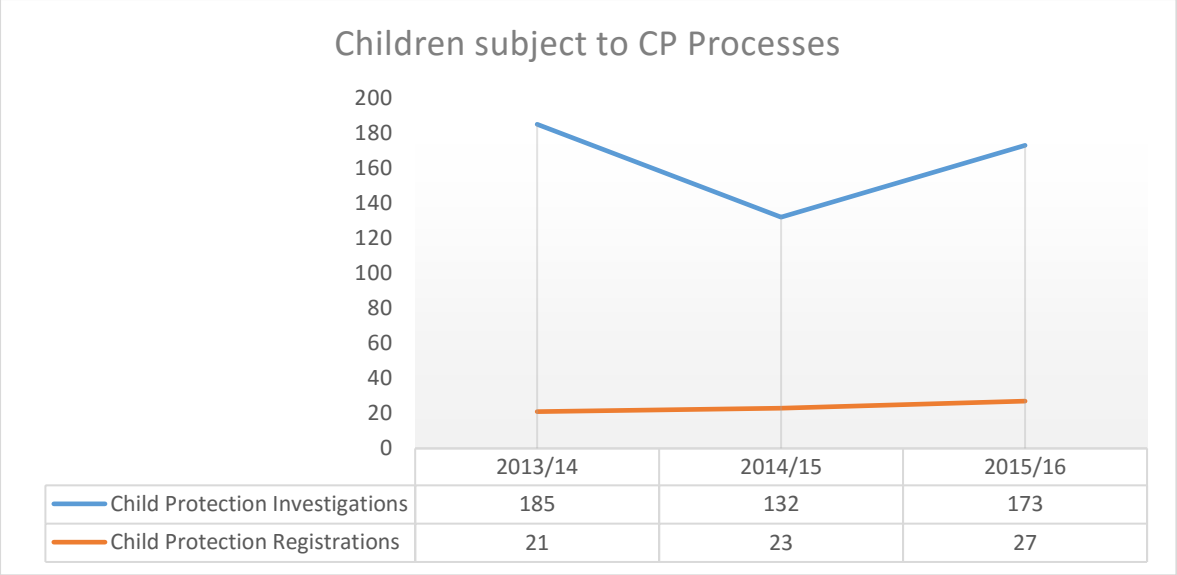
6.1 Number of Children Referred

The number of new referrals to Children and Families has increased by 13.6% (154) in 2015/16 from 1131 to 1285. This trend is confirmed by the increase in the number of children subject of a new referral (10.7%) over the same period. Children and families continue to work with the majority of children and their families on a voluntary basis.

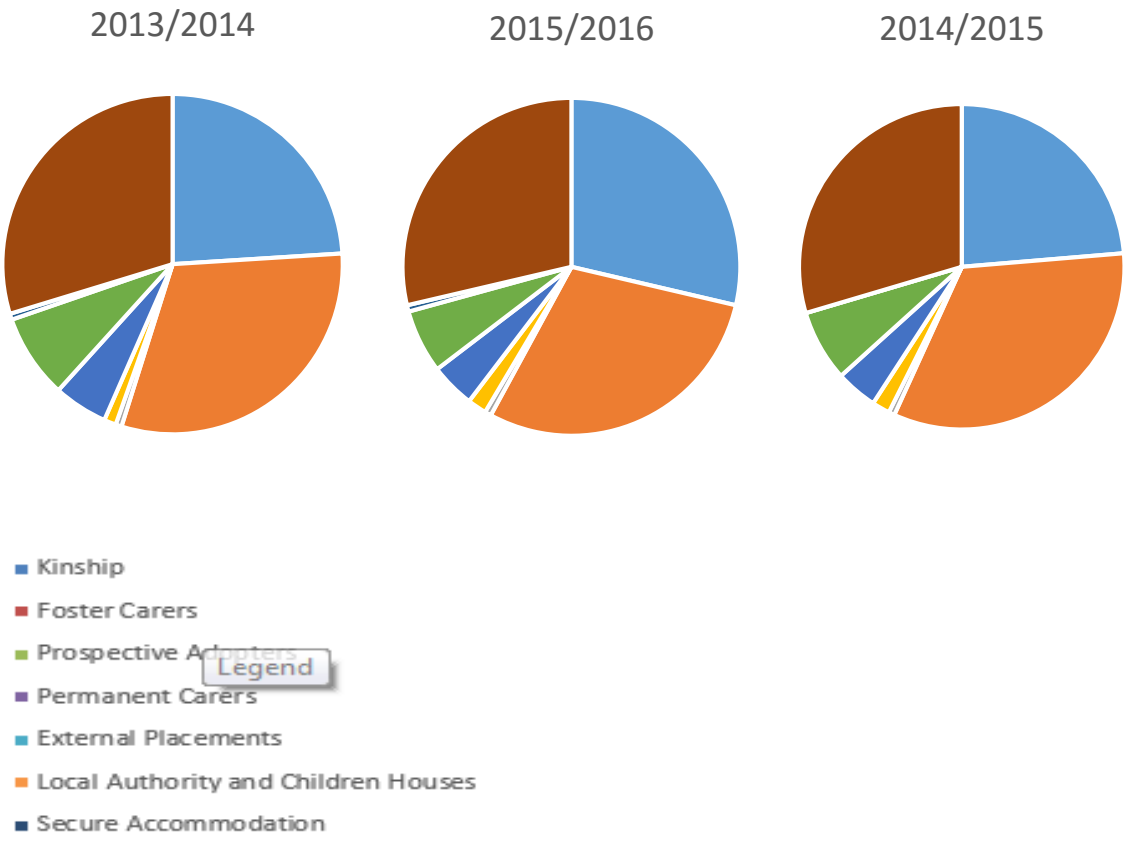


6.2 Number of Children Subject to Child Protection Processes

The number of Child Protection Investigations has increased by 41 in 2015/16 from 132 to 173. While there has been an increase since 2014/15 the figures have remained relatively static over the past 3 year period. CP Registrations remain low at 27, and in 2015 Argyll and Bute was ranked 22nd of the 32 Scottish local authorities, in terms of registration rate/1,000 population aged 0-15.



The number of Accommodated Looked After Children as at 31st March 2016:



Argyll and Bute was ranked 20th of the 32 Scottish local authorities for percentage of the 0-17 population looked after on 31 July 2016 (1.1%), and this was below the 1.5% for Scotland overall.

Argyll and Bute was ranked 8th of the 32 Scottish local authorities for LAC accommodated in a foster care provided by the LA (31%), and performed well against Scotland overall of 25%.

The number of children referred to SCRA is reducing in line with national trend.

Looked After Children - Attainment

2014	1+ SCQF Level 3 or Better	5+ SCQF Level 3 or Better	5+ SCQF Level 4 or Better	5+ SCQF Level 5 or Better	1+ SCQF Level 6 or Better	3+ SCQF Level 6 or Better	5+ SCQF Level 6 or Better	1+ SCQF Level 7 or Better	English	Maths	English & Maths	S4 Cohort Roll
S4 – S6 Looked after	26 – 50.98%	11 – 21.57%	10 – 19.61%	* - 7.84%	* - 11.76%	* - 5.88%	* - 0.00%	* - 3.92%	19 – 37.25%	16 – 31.37%	11 – 21.57%	
2015	1+ SCQF Level 3 or Better	5+ SCQF Level 3 or Better	5+ SCQF Level 4 or Better	5+ SCQF Level 5 or Better	1+ SCQF Level 6 or Better	3+ SCQF Level 6 or Better	5+ SCQF Level 6 or Better	1+ SCQF Level 7 or Better	English	Maths	English & Maths	S4 Cohort Roll
S4 – S6	21 – 100.00%	* - 19.05%	* - 14.29%	* - 0.00%	* - 23.81%	* - 4.76%	* - 0.00%	* - 4.76%	10 – 47.62%	* - 38.10%	* - 28.57%	

*** where numbers are under 10 the data has been suppressed. Cohort figures have been removed to avoid calculating the actual figures**

From 2014 to 2015 there has been a reduction in qualification achieved by Looked After Children. Education led a working group supported by CELSIS to create new guidance to support schools. The new results in August 2016 show significant improvement in number obtaining 5+ SCQF level 3 and a qualification in English with 70 % obtaining an English qualification, the details will be discussed at the next Corporate Parenting Board.

6.3 Fostering and Permanence

Argyll and Bute's standard for Fostering and Adoption are based on the National Care Standard. External inspection of fostering services shows that the service continues to provide very good or good quality of care and support to foster and adoptive carers. The outcomes for children and young people in receipt of foster care has improved are now very good.

During 2015, Scottish Government amended the Adoption and Children (Scotland) Act 2007 which details regulations for fostering. The amendment include: a limit on the number of unrelated children who can be placed with carers, standardising placement descriptors, introduced a learning framework for foster carers; creating a national foster carer database and setting a national minimum rate for fostering allowances and fees. Since December 2015 the limiting of number of children placed with foster carers. The fostering team has had difficulty recruiting despite repeated adverts due to specialised nature of the posts and has required the use of agency staff to support the delivery of the service. The children and

families have been working with Centre for Excellence for Looked After Children in Scotland (CELSIS) to support development of whole service to support all carers.

There are 35 fostering households registered within Argyll and Bute. From the 35 fostering households most are registered to provide respite care with 3 being specifically registered for respite care. The remaining fostering households have 49 children placed either on a temporary or a permanent basis. There is a need to have more carers able to provide short breaks for children with disability.

6.4 Children Placed

The age profile of children and young people placed with foster carers the average age is 3. Traditionally fostering placements are more easily made for babies and young children, Argyll and Bute continue to attempt to recruit foster carers for teenagers.

6.5 Finding a Forever Family

Permanence planning or finding a 'forever family' for Looked After Children has been the priority of all children services. Forever families have been found for children unable to stay with birth parents. A tracker has been developed to provide governance, accountability to make sure each step in the journey is completed timeously to ensure the best outcomes for children.

The target to secure a 'forever family' within 12 months from the decision that a child cannot go home has only occasionally been met. CELCIS have been working closely with Argyll and Bute to support the improvement required. However there has been over 50% increase in the number of children who have been found forever families. This includes four adopters, 5 permanent carers and 4 kinship carers have been assessed and approved at our Fostering and Adoption Panel this year compared to 5 adopters and 1 permanent carer last year.

6.6 Children's Houses

Shellach View – Oban, East King Street – Helensburgh and Dunclutha – Dunoon are the three children's houses in Argyll and Bute providing high quality care and support to young people. External inspection had graded every aspect of care and support in all three houses as very good for a 3rd year. The quality of care is a credit to all the staff within the houses who work tirelessly to support vulnerable young people. Occupancy has been lower in one house to specific circumstance for a young person awaiting court, which brings the overall occupancy to 11.

Children's House	**Total number**
Dunclutha	4
East King Street	5
Shellach View	1 resident and 1 bed being held for young person in the early stages of transition home
Total	**11**

6.7 Throughcare and Alternatives to Care

A small team who work with care leavers or young people at risk of being accommodated in the day, evening and weekends. They provide advice, guidance and support to young people at risk of being accommodated in care and who have moved onto independent living. Under Part 10 of the Children and Young People (Scotland) Act 2014 eligibility to support by young people who have experienced care has increased to a young person's 25th year. Argyll and Bute have a good track record in supporting care leavers and Throughcare currently support 83 young people. The likelihood is that the team will need to continue to expand to meet rising demand for the service caused by higher age bracket.

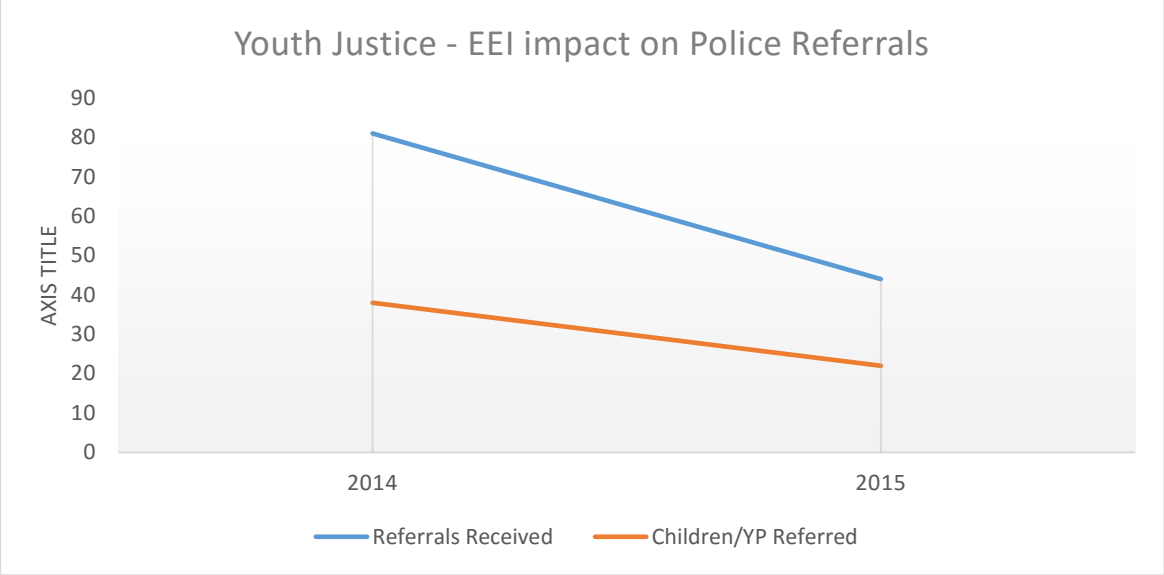
The team go above and beyond to support vulnerable young people, an example was the delivery of Christmas hampers at Christmas to all young people. The team work evenings, weekends when the need arises to provide high quality support. There are many examples of complex young people in crisis and throughcare team providing wraparound support to ensure young people get their tenancy or remain in their local community.

6.8 Services for Children with Disability

Kintyre Network Centre is the only in house provision. It provides good quality support and guidance to 25 young people and their families. External inspection has graded care good. The children's disability support service are provided by different local providers in different models of delivery. Self-directed support has been an opportunity for parents to consider the need of support but adds some risk for small local providers about their financial viability for the future.
Self-Directed support has had a poorer than anticipated uptake within children services there is ongoing dedicated support for self-directed support.

6.9 Youth Justice Service

Youth Justice is delivered by area and criminal justice team. The early screening identification has allowed young people to support early. The process known as Early Effective Intervention has seen all Police referrals for offence and non-offence referral routed to a multi-agency group to be appropriately actioned.



The rate of referral of referrals to SCRA have shown a significant reduction since the implementation of a whole system approach. The referrals for youth offending show an almost 45% reduction. All agencies appear to be moving towards an organisation culture that views offending as a wellbeing issue as well as a law enforcement one.

A good example is the multi-agency screening group, that meets weekly to provide early identification of vulnerable young people and puts support around them to address any issues. This multi-agency response has reduced youth offending across Argyll.

7. Adult Protection: Adult Support and Protection (Scotland) Act 2007

The Act provides the framework for the Adult Protection agenda and came into force in October 2008. During 2006/07 a new set of inter-agency procedures were drafted and approved by the Council, NHS Highland and Strathclyde Police for operational use. This resulted in an extensive programme of training across the agencies noted and the voluntary sector in Argyll.

Changes to the procedures and data collection mean that better information is now available about the outcome of referrals and how many adults are considered at risk of harm etc. The Partnership submits data now to Scottish Government on an annual basis.

There is an ongoing upward trend in adult protection referrals to area team.

Updated data collection methods have resulted in much clearer information being available about those referrals that lead to an adult protection investigation. This has demonstrated the value of referrals from a wide variety of agencies, and in particular the high degree of engagement with our provider services. Detailed reporting and analysis of all aspects of adult protection work is now a key area for discussion at the Adult Protection Committee, with specific measures identified as part of the APC Improvement Plan and associated scorecard. The Adult Protection scorecard is now also available on Pyramid which improves access for our managers and ensures the improvement plan is a live document.

In order to develop a realistic understanding of all aspects of adult support and protection, self-evaluation continues to be a key feature of work undertaken by all those involved in this work. A multi-agency case file audit has been undertaken each year since 2012.

Training on adult support and protection continues to be provided to staff from any agency across Argyll and Bute, including the largest islands. An annual training programme is in place and is publicised via the Argyll and Bute council website.

8. Criminal Justice Services

Our Criminal Justice service comprises a range of activities to support decisions made by the Court, to facilitate completion of community based sentences and the successful reintegration of prisoners following release. The service works with other agencies, both within the Council and beyond, including: Police Scotland, the Scottish Prison Service, NHS Highland and Glasgow and a range of third sector providers. The core function is to provide statutory supervision to the offender via Community Payback Orders and/or post release arrangements, assessment reports to Court and parole boards to assist decision making, and contribute to the Multiagency Public Protection Arrangements (MAPPAs) that manage high risk offenders in the community. The Criminal Justice service is delivered within a partnership with East and West Dunbartonshire Councils. Argyll and Bute's reconviction rate is lower than the Scottish average and that of the Criminal Justice Partnership.

Reconviction Frequency Rate – 2013/14	
Scotland	28.3
Partnership	27.8
Argyll and Bute	25.6

During 2015/16 MAPPA arrangements were extended to include certain high risk violent offenders in addition to sex offenders. This year also saw the introduction of new risk management templates that provide an improved framework for recognising early warning signs and contingency planning. During this time MAPPA was subject to a joint thematic review by the HM Inspectorate of Constabulary in Scotland and the Care Inspectorate (Nov 2015), and whilst a number of national recommendations and areas for development were identified, Inspectors directly observed review meetings and were very positive about the local delivery of MAPPA in our area. Likewise, a recent quality assurance case file audit of MAPPA cases this year reflected a positive delivery of risk management in the community.

A theme in recent years across social work and criminal justice is positive outcomes for people and communities. Community Payback through Unpaid Work is a key strategy for criminal justice and provides opportunities for offenders to make amends but also build on skills that will improve choices and encourage positive citizenship. In the past year we have had at least 4 service users directly continue volunteering with organisations that they had been placed with once their order had been completed, and another 3 (that we know of) who have obtained employment directly as a result of gaining new skills or confidence whilst on Unpaid Work.

9. Child Protection

Child protection is delivered through seven area teams working in partnership with Police Scotland, Education, Health, 3rd sector and communities. The Child Protection Committee (CPC) provides robust multiagency leadership, direction, governance, scrutiny, challenge and support to all services.

In 2015/16 the focus has been to continue the improvement journey prioritising identification and improving the quality of assessment to ensure the needs of vulnerable children's timeously.

The CPC delivers leadership through the Child Protection Business Plan, a multiagency plan mapping priorities for all agencies in delivering Child Protection in Argyll and Bute. The success of the plan is measured through performance scorecards developed on the Council's pyramid management information system.

Multiagency Self-Evaluation

Given that registrations were lower than the national trend, the CPC commissioned WithScotland to undertake an independent evaluation. WithScotland are experts within the child protection field. Their evaluation found key strengths in Argyll and Bute and some areas for development. The With Scotland report provided a perspective on what might have changed in the past three years since the Joint Inspection of Children Services.

The review team were impressed with the professionalism and reflectiveness of all staff. The dedication of multi-agency professionals to meet each child's needs was striking. It was clear from focus group discussions that children are at the heart of practice. Families were thought to generally engage well with GIRFEC; for example attending Child's Plan meetings, which suggests that families knew what to expect, felt less threatened and engaged better.

The quality of inter-agency working and communication was a significant feature to emerge from the case file reading, focus groups and follow-up survey, and appeared a conduit for robust safeguarding. The relationships and communication across some areas was more developed than in others, but this was attributed to changes in staff and new relationships being formed rather than barriers to effective communication. WithScotland were particularly impressed by the sense of nurturing and respect staff had for each other across the agencies with supportive senior management.

As yet, there is no national research, which links GIRFEC with safer outcomes for children. It has been suggested that outcomes depend on how well interventions are tailored to match the circumstances and how manageable those circumstances are (Daniel 2015).

It is difficult to capture the complexity of routine interventions and attributing outcomes in the context of external variables, however, the positive culture for multi-agency challenge

and dialogue and Argyll and Bute's ongoing commitment to self-evaluation should provide a solid basis for moving forward.

WithScotland findings suggest that perhaps Argyll and Bute is following the national trend more closely than first thought in terms of child protection activity. The picture is likely to be more complex on whether a decrease in registration is the result of GIRFEC. On one hand, the quality of inter-agency working and communication does appear to result in early intervention for children and families within Argyll and Bute. On the other, the needs and risks for some children may not be fully understood or identified at this earlier stage.

The picture that emerged through discussions with staff and the survey is not always reflected in the case files and through recording systems. It was difficult to determine the effectiveness of GIRFEC in Argyll and Bute as the quality of assessment, use of chronologies outcome focused plans and reviews were variable. WithScotland suggested more robust evaluation measures are needed to determine whether practice is required to measure the success of early intervention. These themes as well as more consistent care planning, are the focus of 2016/17 Child Protection Business Plan.

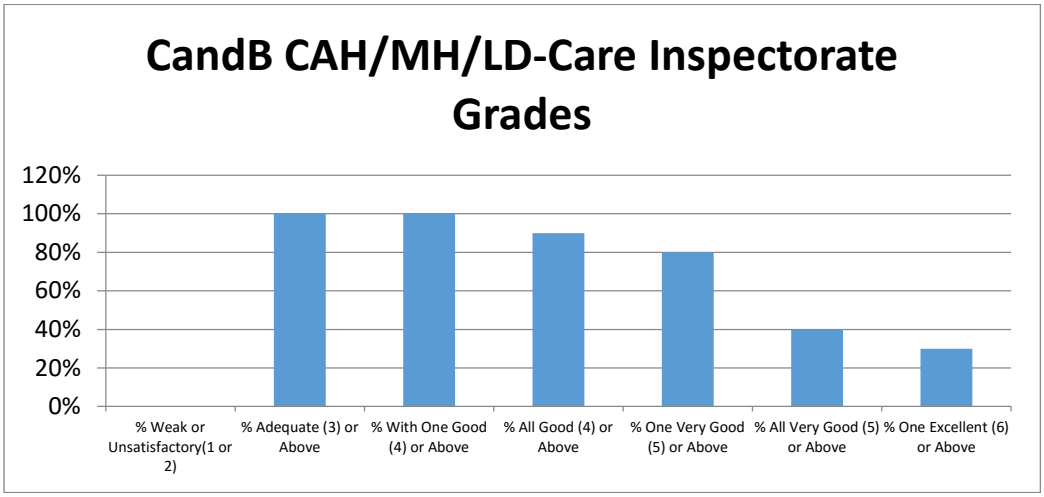
Getting it Right for Every Child (GIRFEC)

Throughout 2015/16, Argyll and Bute Getting it Right Executive group has continued to provide leadership, direction and strategic support to ensure GIRFEC is embedded across all services. The executive group have developed policies, training, learning tools and self-evaluation model to support the implementation of parts 4,5,18 of the Children and Young People Act 2014.

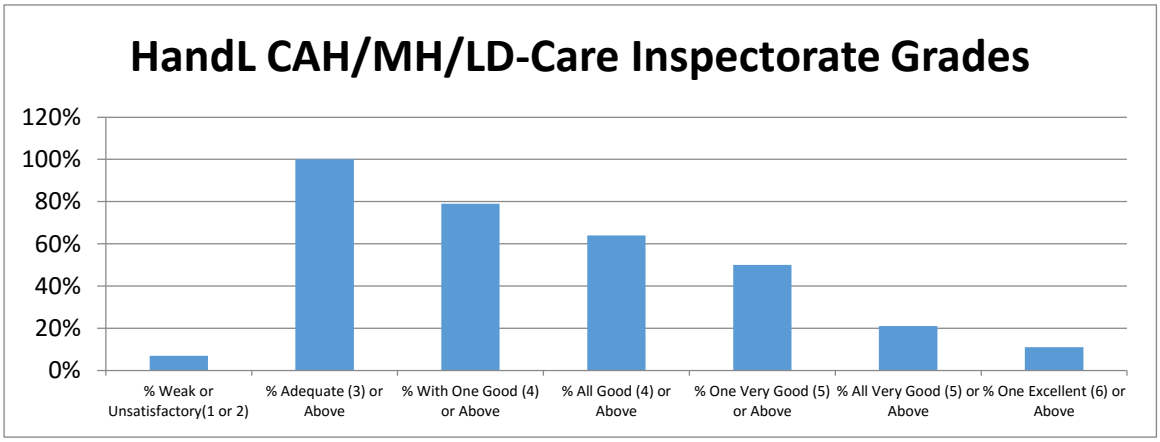
Argyll and Bute is well prepared for the implementation of the Act and across all our agencies a similar assessment tool has been adopted and identical care plans so the vision of "one child, one assessment, one plan" is realised. The self-evaluation model has demonstrated significant improvement in the quality of assessment and improvement required in the quality of care plans.

10. Care Service Inspections

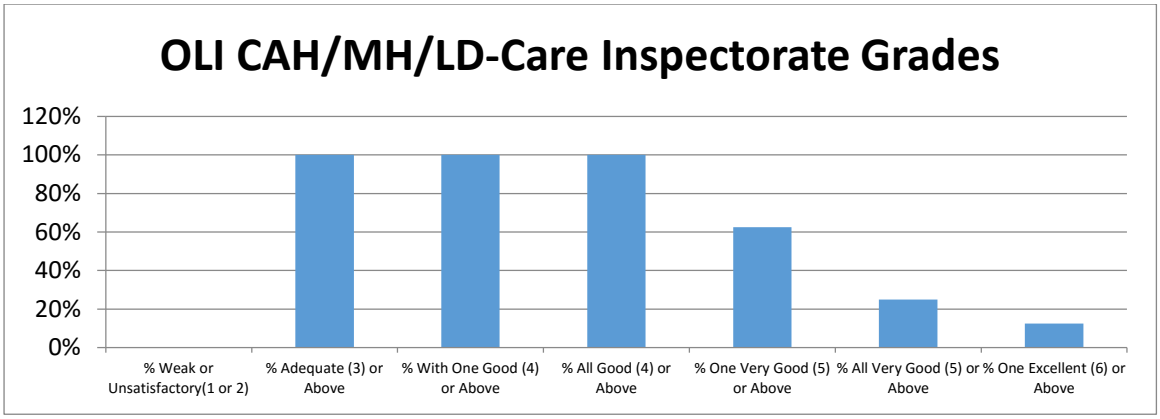
Inspections by Locality



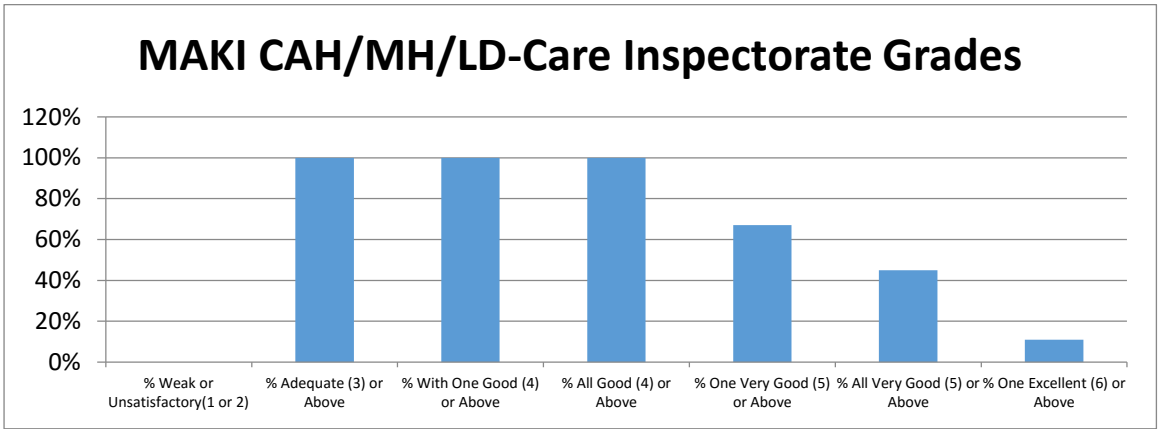
There are currently 10 providers registered in C&B with the care inspectorate for Care at Home, Mental Health and Learning Disability. During the financial year 2015/16 all of these services received a care inspection.



There are currently 14 providers registered in H&L with the care inspectorate for Care at Home, Mental Health and Learning Disability. During the financial year 2015/16 12 of these services received the care inspection. The remaining are likely to be inspected during the current financial year.

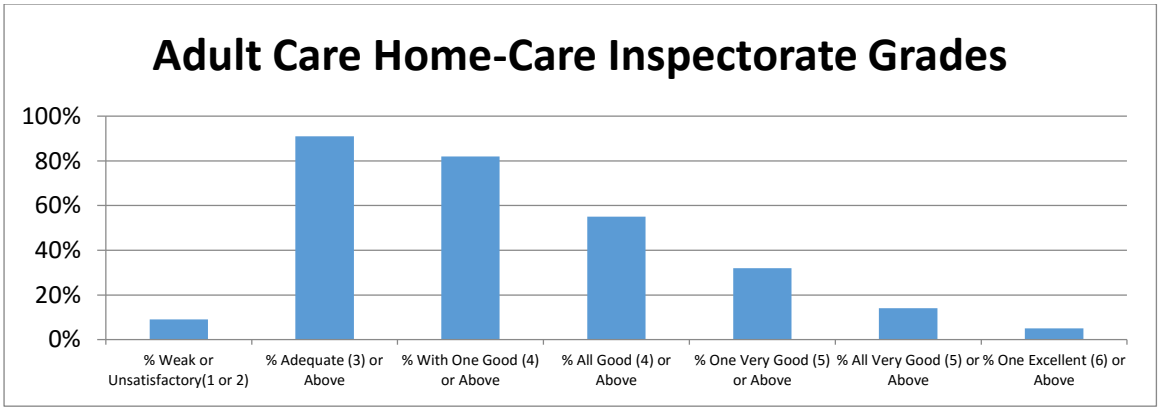


There are currently 8 providers registered in OLI with the care inspectorate for Care at Home, Mental Health and Learning Disability. During the financial year 2015/16 9 of these services received a care inspection with other inspections to be carried out this financial year.



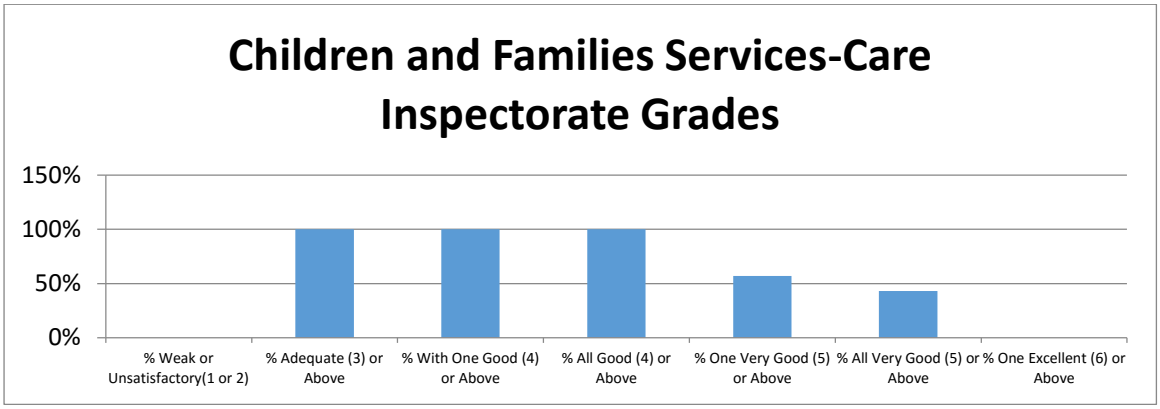
There are currently 9 providers registered in MAKI with the care inspectorate for Care at Home, Mental Health and Learning Disability. 1 of these services is a young person's provider. During the financial year 2015/16 8 of these services received the care inspection. The remaining are likely to be inspected during the current financial year.

Adult Protection – Home Care Inspections



There are currently 22 adult care home services registered with the care inspectorate. 6 of these services are internal; the remaining 16 are external providers. During the financial year 2015/16 24 inspections were carried out on these services. The remaining are likely to be inspected during the current financial year.

Children and Families Inspection



There are currently 7 children and families services registered with the care inspectorate. 3 of these services are internal children's unit's, the remaining 4 are external providers. During the financial year 2015/16 5 of these services received the care inspection. The remaining are likely to be inspected during the current financial year.

11. Health and Social Care Partnership (HSCP) – Moving to Locality Work

Social Work and Health Services have placed significant emphasis on localities and community. As part of the HSCP 3 year strategic plan, 8 locality planning groups have been developed to deliver the HSCP strategic plan at a local level. The design of the integrated management structure supports a move towards a locality based model of delivery. Together services will work with communities to develop more resilient communities. The local planning group began developing across 2015/16 and went live on 1st April 2016.

12. User and Carer Involvement

Our Adult Services actively involve service users and carers in the development of care plans As part of the Joint Older People inspection over 100 older people and their carers were involved and gave views about the quality of their care. Throughout 2015/16 and alongside the development of HSCP strategic plan we actively sought the views of communities to help develop 6 areas of focus for the next 3 years.

13. Carers

The HSCP are committed to working effectively with our carers' centres across Argyll and Bute. The staff in the centres work very closely with our local teams to ensure a wide range of carers have access to support in their own localities. The main challenge looking forward is how we develop our joint working with the carers network as the new legislative duties and responsibilities of the new Cares Act 2017 come into force next year.

The fostering service organise training and development events for the foster carers which also provide an opportunity to consult directly with our carers. The events are also open to adopters. Child care is arranged for the children and young people (a crèche for the under 5s and outdoor Stramash activities for the older children) to maximise attendance. The

events occur twice yearly with the last two being on the 15th November 2015 and the 19th March 2016. The events are always well attended and well evaluated.

14. Parents Engagement at Meetings

Parent's engagement at child protection conference and within Looked After Children reviews is an area that requires improvement. The returns form questionnaires are low and parents often choose not to have a follow up interview once the processes are concluded. Argyll and Bute have commissioned ChildLine to undertake some follow up activity on social work behalf to ensure families views are being fed into child protection improvement journey.

15. Young People and Children

Children 1st and Who Cares Scotland are advocacy services commissioned by Argyll and Bute Council to support children and young people within the child protection or looked after processes. All children and young people within this process are offered support and advocacy. In addition our Care Assessment and Reviewing Officers, who chair these meetings, ensure children and young people's views are fed into assessments and care planning using different tools. Often Viewpoint, an electronic questionnaire, is used or for older young people the Care Assessment and Reviewing Officer will meet prior to the meeting. In 2015/16, 168 Viewpoint questionnaires were used to support young people to voice their views within both care planning and formal processes.

16. Corporate Parenting

The Corporate Parenting Board oversee and monitor how members of Community Planning discharges duties of corporate parents.

It ensures that Argyll and Bute Council takes its corporate parenting responsibility seriously. Chaired by Councillor Mary-Jean Devon with four Children's Champions - Councillor McAlpine, Councillor Marshall, Councillor Robertson and Councillor Corrie – and their unwavering commitment and drive ensures that all partners are working together to make a difference in the lives of looked after children and care leavers.

During 2015/16 the Board has supported many initiatives and has had numerous successes:

- Successful in attracting £220,000 additional funding from Like Chances Trust to support greater participation by young people
- Securing support and consultation to build a new Children's Unit in Dunoon
- Governance for outcomes for looked after children including improvements in permanence (Forever Families) and employment opportunities
- High Quality Care – very good inspection results across the board

17. Key Challenges for the Year Ahead

17.1 Health and Social Care

The implementation of Health and Social Care Partnership (HSCP) brings unique opportunities and challenges. Councils have statutory responsibility for Social Work and HSCP deliver this on the Council's behalf. The changes in governance structure will be challenging for Officers, Elected Members as the new structure becomes embedded. In the future as the locality groups develop these groups will be central to redesigning services to meet the needs of local communities. The continued move towards reshaping our model of care will involve a number of service redesign projects as we meet the challenge of demographic changes. Our new three year strategic plan for health and social care outlines our six key areas of focus.

17.2 Adult Care

Residential Provision

The re-provision of the Council care homes, whether it is in-house or in partnership with independent providers and/or Housing Associations will require ongoing engagement with the political membership of the Council and the local communities as we develop alternative models of care.

Delayed Discharge

Whilst we have been successful in managing Delayed Discharges, the review of national target from 4 weeks to 2 weeks in April 2015 represented a huge challenge for all partnerships across Scotland. With the national target shifting to 72 hours from April 2016, the focus for the partnership has been to ensure people are able to go home with appropriate support to live at home safely.

Adult Protection

Adult Protection work continues to grow and increasingly creates capacity issues in our ability to respond to the high number of initial referrals from the Police. The Adult Protection Committee are focusing this year on issues relating to financial harm and facilitated a conference in Argyll and Bute to consider the complexities of financial abuse in day to day practice.

Autism

Implementation of the Strategy for Autism across health and social care services is currently under review with a new more representative Autism strategy group actively working with Autism Network Scotland to develop an implementation plan centred on the four new national outcomes for Autism. It is expected the Autism group will have the implementation

plan completed by the end of August 2016. This plan will set the direction of travel for the next five years and identify key actions with timescales built into the implementation plan.

Criminal Justice

The planned organisational changes within Criminal Justice mean that although implementation will not happen until 2017, Community Planning Partnership will have duties for delivering Criminal Justice Services. The funding for Criminal Justice Service and the delivery model will be developed throughout 2016/17

Corporate Parenting

In line with the Children and Young People's (Scotland) Act 2014, we continue to promote the wellbeing of looked after children and care leavers. The Corporate Parenting Board and Argyll and Bute Council's challenges in supporting looked after children are:

- Improving LAC attainment
- Supporting those aged between 16 and 25 years within the new Act with financial restraints and redesign will be required to meet increasing demand within a reduced financial envelope.

Getting It Right For Every Child (GIRFEC)

The GIRFEC framework for supporting whole families to support a child is fully embedded in Argyll and Bute however the new responsibilities within the Children and Young People's Act will need strong leadership and partnership with Education to ensure its continued success

Child Protection

All services work together to ensure our children are safe, however we know that the world is changing with new technical knowledge and social media having changed how children and young people engage with the wider world. In 2016/17 the Child Protection Committee will focus on children at risk of sexual exploitation and internet safety in addition to the core business of identifying, assessing and planning. There needs to be a focus on self-evaluation to ensure the improvement journey we have undertaken maintains the improvement.

18. Feedback on our Services

The Commissioning Team supports the evaluation of services through seeking the news of those who use the service. While the returns on questionnaires are limited the following was found

18.1 Care at Home

Whilst we have been active in re-designing older people's services we will need to continue to do so in order to prepare for the pressures of demographic change and the continued

public expectation for improvement in services and care at home. Our ability to recruit staff into home care services in particular presents a significant challenge for the Council and those providers we commission from.

83% of service users felt care workers completed all tasks required during visits.
97% of service users felt they were treated with dignity and respect at all times.

18.2 Care Home

The high level of customer satisfaction in relation to care home provision across Argyll & Bute is listed below:

97% of service users are happy with how well staff do their jobs.
95% of service users agree that their rights to a private life within the home are respected
99% of service users agree that staff are polite and friendly.
98% of service users agree that staff are sensitive to their needs.

19. Journey of Improvement

The Health and Social Care Partnership is an opportunity for the HSCP to bring together the Highland Quality Approach and Performance Improvement Model (PIM). HQA supports improvement methodology to support change, reduces duplication and support LEAN working. While the PIM model is used by the Care Inspectorate Scotland to evaluate how effective services are delivering improved outcomes for older people, children and families.

Children and families have supported national collaborative's such as the Early Years Collaborative. Improvement methodology through Plan, Do, Study, Act (PDSA) cycle have been introduced in early years and rolled out to social work service. Starting small, collecting data, testing changes has become part of the self-evaluation and improvement tools used across children's services.

20. Forever Families

Argyll and Bute are participating in a research study with Stirling University and British Adoption and Fostering. The study follows a group of children across 16 local authorities to look at how processes have worked to find vulnerable children forever families. Centre of Excellence for Looked after Children (CELIS) have been working with staff in Argyll and Bute. Providing training, individual support and mentoring, this has improved the staff confidence. More confident staff coupled with more robust monitoring has improved how we support children to find their forever families.

21. Inspection of Older People Services

An inspection of older peoples services was completed in 2015 and the partnership are now working on a series of improvement actions to address eleven recommendations made by the Care Inspectorate and Health Care Improvement Scotland. Our progress will be monitored by our Link Inspector during the next 3 years. We achieved seven 'adequate'

and two 'good' grades. This gives the Health and Social Care Partnership a solid foundation to build on as we move forward.

22. Workforce Planning and Development

Workforce planning is delivered by the Social Work Training Board. The board funds and supports social care to undertake the necessary qualifications to maintain their registration with the regulatory body, the Scottish Social Service Council (SSSC).

The training board, CPC, APC and Council provide support to ensure staff feel confident and competent to undertake their statutory duties. In 2015/2016 over 80 courses were offered and there was social work attendance for 1037 days. Post Registration Training (PRTC) is a required of registration with the SSSC. These courses are developed as a direct consequence of identified learning through Professional Review Development and statutory requirements placed on the council and social care. Last year Adult Care completed 82% of PRD's and Children and Families 85%.

12 employees have completed the Argyll and Bute manager award with a further 18 currently undertaking the award. In addition staff can access e-learning through LEON (Learning Electronically Online) system.

Professional qualifications undertaken to support registration include:

SVQ3 Social Services (children and young people)	6
SVQ4 Social Services (children and young people)	3
K101/DD102 Open University Foundation	7
OU BA(hons) Social Work Scotland	3
Certification in Adult Services, Support and Protection	1
Mental Health Award	2

23. Argyll and Bute Grow our Own Scheme

Within Argyll and Bute there is difficulty recruiting social workers, it is for this reason that a "grow our own" scheme was developed. Each year council sponsor two applicants to undertake the degree in social work. In addition to University teaching, the course includes two 100 day compulsory social work placement which require staff to be absent from their present post during placement. One of the placements is external to Argyll and Bute. The "grow our own" scheme is an opportunity for Argyll and Bute to support talented individuals to undertaken their social work qualification.

24. Modern Apprentices in Health and Social Care

The Argyll and Bute Council Modern Apprenticeship Programme offers young people aged between 16-19 years the opportunity to develop both their vocational and personal skills in a working environment.

Within our multi-disciplinary social work team, we recognised a new opportunity for a

Modern Apprentice (MA) in health and social care. Across social work four young people have been offered modern apprenticeships.

25. Example Good Practice

25.1 Unpaid Work

Our work squads have continued to support community gardening projects working alongside other volunteer groups and our Scheme Manager has been invited to meet the Princess Royal to discuss our work, when she visits Lochgilphead in September, in recognition of the work we have undertaken at the Mid Argyll Swimming Pool.

25.1 Good Practice – Cowal and Bute – Extended Community Team

Occupation, Physiotherapy, social work, community nurses working together to support people in the community. Working to support older people in their own home. Using regular virtual wards, meeting to ensure they understand the needs of the service user and planning for people leaving hospital. Supports improvement in delay discharge and support in the community.

25.2 Case Study 1 - Self-directed Support

59 year old female, lives alone in a top floor flat and has multiple health concerns including Chorea, an abnormal involuntary movement disorder, one of a group of neurological disorders; Graves disease, an auto-immune disease which affects the thyroid, frequently causing it to become overactive, with related hyperthyroid symptoms such as increased heartbeat, muscle weakness, disturbed sleep, and irritability. Client has also suffered from depression and anxiety.

The supported person was assessed as requiring care at home to maintain living in the community. At the time of assessment the supported person was given details on the 4 options available under Self Directed Support. She discussed these options with the Self Directed Support Officer and the Care Manager and felt that she was not capable of becoming an employer under Option 1 (Direct Payments) as she did not have the confidence or drive and was exhausted. She opted for an Option 3 (arranged services). However within 3 months, the supported person contacted her Care Manager and explained that the service she was receiving was not suitable for her and that it was not meeting all of her outcomes - she was becoming more anxious because she did not know if the care staff would show. She did however manage to get out of her house with support from the carers and a voluntary organisation plus had attended some groups and workshops. By attending the workshops, the supported person felt she was becoming more educated and she was able to meet people in a similar situation to herself.

The supported person studied the 4 options and decided that she would like to hire her own personal assistants. The Self Directed Support Officer met with her again and started a step by step plan on what she needed to arrange in order to become an employer through an option 1.

Since choosing option 1, the supported person has become more confident in herself, and felt empowered and in control of her care. She is now achieving her goals and outcomes with the support of her Personal Assistants and is striving to be more independent. She is now able to travel with the support of her Personal Assistants and is making her hospital appointments, getting her own shopping and has visited her family. The supported person still requires assistance with her personal care and meal preparation but she is able now to do more for herself.

Working closely with the supported person and being honest and open about her ability to make her own choices has empowered the supported person to achieve the goals and outcome set out on her support plan.

Main Benefits and Impacts

At the time of assessment the supported person's mental and physical health was on the decline. She was isolated in her home and did not have the opportunity or confidence in being part of her outside community. She was missing important hospital appointments and was becoming increasingly anxious and down in her mood.

The timeframe that was worked towards made a considerable difference to the supported person's critical health. It would appear that there was a window of time to enable the supported person to be a more confident individual and have the confidence to maintain her own life and continue to be part of the community.

The timeframe and multiple visits to the supported person enhanced her control of her life. We encouraged a multidisciplinary approach with the involvement of health professionals, the care provider, voluntary sector and social care.

Communication between sectors and the supported person would appear to have a beneficial impact for the supported person as she learned how to speak out, be involved and be in control.

Case Study 2 – Self-directed Support

A 24 year old man with Cerebral Palsy lived with his mother (mother & father are divorced). He spent occasional weekends with his father and was supported by both parents. The young man came to the decision that he would like to start being more independent of his parents so, with support from his allocated care manager, he secured an adapted flat which he has now moved into.

The supported person is mainly self-sufficient in his wheel chair although he does require support when out in the community with assistance to get to and from appointments. He may also require personal care at times.

He still receives some ongoing support from his care manager to build confidence and ensure that all aspects of him being independent are covered i.e. paying bills, shopping,

appointments, etc. Mum lives close by and can be there when needed, however, the young man has explained that he wants to do these things for himself to meet his goals and agreed outcomes.

Through Self-directed Support and the four options available, the Self-directed Support Officer and Care Manager discussed with him how he would like to be supported to live independently. He decided to go for an Option 1 - Direct Payments because he can use the Personal Assistant flexibly. He also wanted to be in control of who was going to support him and this was very important to him. With support from a voluntary service, he has a hired a Personal Assistant who is a man with years of personal care and support experience and also has similar interests.

The young man has now become empowered to take risks whilst embracing new challenges that he would not have taken when living at home. His confidence has increased and he is socialising with other people of his own age. He is managing his Direct Payment with assistance from mum and a payroll agency. However he has incredible IT skills and can manage most of the payroll details himself either online or via email as he prefers to communicate this way as at times he can struggle verbally.

Feedback from Service Users

"Three years ago, a fifteen year old stands in a social work office to be told they are being put into residential care. 50 miles away from her family and friends and all the other things that make up her life and she sees no future. Three years later an eighteen year old stands in a social work office discussing plans for moving to University, away from her family and friends but this time the prospect isn't so scary."

"Meeting other carers, supporting and sharing is fabulous" – Foster Carer March 2016

"I want to go home to stay with my parents but my social worker has helped me to understand the risks at home" – Young person

"The new handbook for foster carers is a good tool" – March 2016

"Satisfied at the moment so long as nothing changes. It provides me with help in the social aspects ie independent living." – (Adult Supported Living)

"The boys that support my son are very good with him but as his mother and XX get 24/7 support and I will always make sure his needs are met, I am lucky". – (Adult Supported Living)

"My mum is very much loved and cared for in X. Wonderful staff from the office care, kitchen, laundry and domestic and I am kept informed of everything and any worries or concerns I may have are dealt with immediately. Wonderful place, couldn't give them enough praise." (Care at Home)

"All the staff are absolutely fantastic and are a credit to the council. Thank them all!"

"My mother has severe dementia and is looked after very well, she is always clean and well dressed and seems content in her own little world." (Care at Home)

"I feel that my mum gets treated well at X and as I have said they do their best to include my mum, they contact myself if there is anything to discuss." (Care at Home)

"My mum has very recently come to live with me following discharge from hospital. X Homecare have been excellent in this period of transition and the carers have been sensitive to both my mum's increased needs and also my own as her closest family." (Care at Home)

"The support staff are extremely good at helping with washing and dressing. They are always cheery and happy to prompt with my medicines and are also flexible when I have appointments. I couldn't fault the quality of service but the timings could be improved and I haven't been involved in group/community activities." (Care at Home)

"Regular carers are needed and the good ones are taken advantage of. When they change carer they should come as a pair to introduce the new person and not leave this person to find out where the house is and who the person in need of care is also." (Care at Home)

Psychology of Parenting

A pilot for the Scottish Government have ran parenting support groups in all 8 localities in Argyll and Bute. Training staff and supporting parents to undertake a structured parenting programme with incredible feedback from parents. Here is some feedback:

During the session. "OMG this is so helpful, no one told me about parenting stuff. All I knew was what the midwives told me, nothing after that (Big proud smile!)

"Since I've done the PoPP parenting classes, I can't help but notice other parents doing it wrong (struggling). I want to give them advice but then I remember what it was like for me. I do share what I have learned with my friends and they appreciate my advice "

Feedback from other psychology parenting groups

"It gave me something to look forward to. It became part of my routine."
"By the end of the first session, I can mind thinking "I need this". I wasn't getting judged."
"It was relaxed, you can have tea and coffee, it is very friendly."
"I loved it. I wished it was longer."
Changes parents/carers noticed:
"Better behaviour, more fun, better relationship, not so stressful."
"Look at it from the child's point of view"
"I am a lot calmer now...I don't shout now."
"He is more relaxed because I am more relaxed."
"I have a lot more patience. I know how to deal with things."
"It is good to wake up to happy kids, put happy kids to bed, and fill your day with happy kids."

Glossary

ADP Alcohol & Drug Partnership
ADDACTION
APC Adult Protection Committee
ASIST Applied Suicide Intervention Skills Training
BAAF British Association for Adoption and Fostering
CAMH Children and Adolescent Mental Health
CELIS Centre Excellence Looked Institute
CJA Criminal Justice Authority
CMHT Community Mental Health Team
COPPG Chief Officer Public Protection Group
CPO Child Protection Order
CPCC Child Protection Case Conference
CPP Community Planning Partnerships
CPR Child Protection Registration
CSC Community Service Committee
CSE Child Sexual Exploitation
DD – Delayed Discharges
DP – Direct Payments
EEI Early Effective Intervention
EYC – Early Years Collaborative
H&SCP Health and Social Care Integration
HMP Her Majesty's Prison
HNC Higher National Certificate
IJB Integrated Joint Board
ILG Independent Living Group
IRF Integrated Resource Framework
IRISS Institute for Research and Innovation in Social Services
LAC Looked After Children
MA Modern Apprentice
MAPPA Multi Agency Public Protection Arrangements
MHO Mental Health Officer
NES
NHS National Health Service
NRS
PSC Performance Scrutiny Committee
PRTL Post Registration Training and Learning
PRD – Professional Review Development
POP Psychology of Parenting
SCRA Scottish Children's Reporter Administration
SIMD Scottish Index of Multiple Deprivation
SDS Self Directed Support
SLA Service Level Agreement
SQA Scottish Qualifications Authority
SSSC Scottish Social Services Council
SSE Scottish and Southern Energy
SVQ Scottish Vocational Qualification

The Role of Chief Social Work Officer

Guidance Issued by Scottish Ministers

pursuant to Section 5(1) of the Social Work (Scotland) Act 1968

Revision of Guidance First Issued In 2009

Revised Version – July 2016

This guidance has been developed in partnership with local government and supported by COSLA

The Scottish Government
Riaghaltas na h-Alba

July 2016

INTRODUCTION

1. The Social Work (Scotland) Act 1968 (the 1968 Act) requires local authorities to appoint a single Chief Social Work Officer (CSWO) for the purposes of listed social work functions.

2. This document contains statutory guidance. It is issued to local authorities by Scottish Ministers under section 5 of the 1968 Act. The local authority must have regard to this guidance. It must follow both the letter and the spirit of the guidance. It must not depart from the guidance without good reason. The Guidance replaces guidance previously issued in 2009.

PURPOSE

3. The guidance is for local authorities and will also be of use to bodies and partnerships to which local authorities have delegated social work functions. Local authorities must have regard to this guidance when carrying out their functions under the 1968 Act. Recognising the democratic accountability which local authorities have in this area, clarity and consistency about the role and contribution of the CSWO are particularly important given the diversity of organisational structures and the range of organisations and partnerships with an interest and role in delivery of social work services.

4. This guidance summarises the minimum scope of the role of the CSWO. It will assist elected members in ensuring that the role is delivered effectively and that the local authority derives maximum benefit from the effective functioning of the role. Effective delivery of and support for the role will assist local authorities to be assured that there is coherence and effective interfacing across all of their social work functions.

5. The guidance is intended to:

(a) support local authorities in effective discharge of responsibilities for which they are democratically accountable;

(b) help local authorities maximise the role of the CSWO and the value of their professional advice – both strategically and professionally;

(c) provide advice on how best to support the role so that the CSWO can be effective in their role both within the local authority and in regard to other entities, such as Community Planning Partnerships, whilst recognising that local authorities operate with different management and organisational structures and in different partnership landscapes;

(d) assist Integration Joint Boards (IJBs) to understand the CSWO role in the context of integration of health and social care brought in through the Public Bodies (Joint Working) (Scotland) Act 2014 (the 2014 Act).

(e) be read alongside the wide range of guidance relevant to social work functions of local authorities and relevant guidance issued relating to the 2014 Act.

(f) be sufficiently generic to remain relevant in the event of future management or organisational structural change.

REQUIREMENT

6. The requirement for every local authority to appoint a Chief Social Work Officer is set out in section 3 of the 1968 Act. This requirement is for the purposes of the local authority functions under the 1968 Act and the enactments listed in section 5(1B) of the Act. The role provides a strategic and professional leadership role in the delivery of social work services. In addition there are certain functions conferred by legislation directly on the CSWO by name.

7. The Scottish Office explicitly recognised that the need for the role was driven by "*the particular responsibilities which fall on social work services in that they affect personal lives, individual rights and liberties to an extent that other local authority services do not.*" (Circular: SWSG2/1995 May 1995)

8. The Public Bodies (Joint Working) (Scotland) Act 2014 provides for the delegation of certain social work functions by a local authority to an integration authority. The CSWO's responsibilities in relation to local authority social work functions continue to apply to functions which are being delivered by other bodies under integration arrangements. However, the responsibility for appointing a CSWO cannot be delegated and must be exercised directly by the local authority itself.

THE CHIEF SOCIAL WORK OFFICER ROLE

Overview

9. The CSWO role was established to ensure the provision of appropriate professional advice in the discharge of a local authority's statutory functions as described in paragraph 6. The role also has a place set out in integrated arrangements brought in through the 2014 Act. As a matter of good practice it is expected that the CSWO will undertake the role across the full range of a local authority's social work functions to provide a focus for professional leadership and governance in regard to these functions.

10. The CSWO should assist local authorities and their partners in understanding the complexities and cross-cutting nature of social work service delivery – including in relation to particular issues such as corporate parenting, child protection, adult protection and the management of high risk offenders - and also the key role social work plays in contributing to the achievement of a wide range of national and local outcomes. The CSWO also has a contribution to make in supporting overall performance improvement and management of corporate risk.

11. It is for local authorities to determine the reporting and management structures that best meet their needs. Where the CSWO is not a full member of the senior management team or equivalent, elected members must satisfy themselves that the officer has appropriate access and influence at the most senior level and is supported to deliver the complex role described in this guidance.

Competencies

12. Scottish Ministers' requirement is that the CSWO role will be held by a person who is qualified as a social worker and registered as such with the Scottish Social Services Council. Local authorities will also want to require this as they will need to ensure that the CSWO:

- can demonstrate extensive experience at a senior level of both operational and strategic management of social work and social care services and;
- has the competence and confidence required to provide effective professional advice at all levels within the organisation and with the full range of partner organisations
- receives effective induction to support them in full delivery of their role

(NB At the time of writing, SI 1996/515, which sets out minimum qualifications for a CSWO is being reviewed with a view to amendment so that the social work degree is specifically included.)

13. Further information on the skills and competencies required of a CSWO is available in the Standard for Chief Social Work Officers (issued by the Scottish Social Services Council in July 2015) which underpins the Level 11 Award for CSWOs which was launched in August 2015 as a further professional accredited qualification aimed at enhancing CSWO competence.

Scope

14. The scope of the role relates to the functions outlined in paragraph 6 whether provided directly by the local authority; through delegation to another statutory body or in partnership with other agencies. Where social work services and support are commissioned on behalf of the authority, including from the independent and voluntary sector, the CSWO has a responsibility to advise on the specification, quality and standards of the commissioned services and support. The CSWO also has a role in providing professional advice and guidance to an Integration Joint Board or NHS Board to which social work functions have been formally delegated.

Responsibility for values and standards

15. The CSWO should:

(a) promote values and standards of professional practice, including all relevant national Standards and Guidance, and ensure adherence with the Codes of Practice issued by the Scottish Social Services Council for social service employers.

(b) work with Human Resources (or equivalent function) and responsible senior managers to ensure that all social service workers practice in line with the SSSC's Code of Practice and that all registered social service workers meet the requirements of the regulatory body;

(c) establish a Practice Governance Group or link with relevant Clinical and Care Governance arrangements designed to support and advise managers in maintaining and developing high standards of practice and supervision in line with relevant guidance, including, for example, - the *Practice Governance Framework: Responsibility and Accountability in Social Work Practice* (SG 2011);

(d) ensure that the values and standards of professional practice are communicated on a regular basis and adhered to and that local guidance is reviewed and updated periodically.

16. The CSWO must be empowered and enabled to provide professional advice and contribute to decision-making in the local authority and health and social care partnership arrangements, raising issues of concern with the local authority Elected Members or Chief Executive, or the Chief Officer of the Integration Joint Board as appropriate (or the Chief Executive of a Health Board if appropriate in the context of a lead agency model), in regard to:

(a) effective governance arrangements for the management of the complex balance of need, risk and civil liberties, in accordance with professional standards.

(b) appropriate systems required to 1) promote continuous improvement and 2) identify and address weak and poor practice.

(c) the development and monitoring of implementation of appropriate care governance arrangements;

(d) approaches in place for learning from critical incidents, which could include through facilitation of local authority involvement in the work of Child Protection Committees, Adult Support and Protection Committees and Offender Management Committees where that will result in the necessary learning within local authorities taking place;

(e) requirements that only registered social workers undertake those functions reserved in legislation or are accountable for those functions described in guidance;

(f) workforce planning and quality assurance, including safe recruitment practice, probation/mentoring arrangements, managing poor performance and promoting continuous learning and development for staff;

(g) continuous improvement, raising standards and evidence-informed good practice, including the development of person-centred services that are focussed on the needs of people who use services and support;

(h) the provision and quality of practice learning experiences for social work students and effective workplace assessment arrangements, in accordance with the SSSC Code of Practice for Employers of Social Service Workers;

Decision-Making

17. There are a small number of areas of decision-making where legislation confers functions directly on the CSWO by name. These areas relate primarily to the curtailment of individual freedom and the protection of both individuals and the public. Such decisions must be made either by the CSWO or by a professionally qualified social worker, at an appropriate level of seniority, to whom the responsibility has been formally delegated and set out within local authority arrangements. Even where responsibility has been delegated, the CSWO retains overall responsibility for ensuring quality and oversight of the decisions. These areas include:

- deciding whether to implement a secure accommodation authorisation in relation to a child (with the consent of a head of the secure accommodation), reviewing such placements and removing a child from secure accommodation if appropriate;
- the transfer of a child subject to a Supervision Order in cases of urgent necessity;
- acting as guardian to an adult with incapacity where the guardianship functions relate to the personal welfare of the adult and no other suitable individual has consented to be appointed;
- decisions associated with the management of drug treatment and testing orders
- carrying out functions as the appropriate authority in relation to a breach of a supervised release order, or to appoint someone to carry out these functions.

18. In addition to these specific areas where legislation confers functions on all CSWOs, there will be a much larger number of areas of decision-making which have been assigned by individual local authorities to Chief Social Work Officers reflecting "*the particular responsibilities which fall on social work services in that they affect personal lives, individual rights and liberties to an extent that other local authority services do not*" noted in paragraph 7. These areas may include responsibilities assigned through guidance or other routes. For example:

- the 2014 guidance on Multi Agency Public Protection Arrangements (MAPPA) makes explicit reference to the role of the CSWO in responsibility for joint arrangements, in co-operation with other authorities.
- although mental health services are delegated to Integration Joint Boards, some of these functions require to be carried out by local authority officers with a social work qualification (Mental Health Officers). Local authorities will want to be reassured via the CSWO that these functions are discharged in accordance with professional standards and statutory requirements

It is for each local authority to make transparent which additional specific areas of responsibility in regard to their social work functions they have assigned to their CSWO

Leadership

19. The CSWO is responsible for providing professional leadership for social workers and staff in social work services. The CSWO should:

(a) support and contribute to evidence-informed decision making and practice – at professional and corporate level – by providing appropriate professional advice;

(b) seek to enhance professional leadership and accountability throughout the organisation to support the quality of service and delivery;

(c) support the delivery of social work's contribution to achieving local and national outcomes;

(d) promote partnership working across professions and all agencies to support the delivery of integrated services;

(e) promote social work values across corporate agendas and partner agencies.

The CSWO role in the context of partnerships and integration

20. In the context of Health and Social Care Integration and the 2014 Act, the CSWO is required to be appointed as a non-voting member of the Integration Joint Board (IJB) (or, in lead agency models, the Integration Joint Monitoring Committee). Scottish Ministers are strongly of the view that the influence of high quality professional leaders in the integrated arrangements is central to the effectiveness of improving the quality of care locally and nationally.

21. The CSWO also has a defined role in professional and clinical and care leadership and has a key role to play in Clinical and Care Governance systems which support the work of the Integration Joint Board, as set out in the partnership Integration Schemes and relevant guidance.

22. The local authority should ensure that appropriate arrangements are in place to include the CSWO in relevant strategic and operational forums that provide direct access to the Chief Executive and elected members so that the CSWO is in an optimum position to support and advise them in regard to their social work function responsibilities in their partnership contexts.

Reporting

23. The CSWO has a role in reporting to the local authority Chief Executive, elected members and IJBs – providing comment on issues which may identify risk to safety of vulnerable people or impact on the social work service and also on the findings of relevant service quality and performance reports, setting out:

- implications for the local authority, for the IJB, for services, for people who use services and support and carers, for individual teams/members of staff/partners as appropriate;
- implications for delivery of national and local outcomes;
- proposals for remedial action;
- means for sharing good practice and learning;
- monitoring and reporting arrangements for identified improvement activity.

24. The CSWO should also produce and publish a summary annual report for local authorities and IJBs on the functions of the CSWO role and delivery of the local authority's social work services functions (however these are organised or delivered). A template for this report is available from by the Office of the Chief Social Work Adviser, Scottish Government.

ACCESS, ACCOUNTABILITY AND REPORTING ARRANGEMENTS

25. To discharge their role effectively, the CSWO will need:

(a) direct access to people and information across the local authority, including the Chief Executive, elected members, managers and frontline practitioners and also in partner services, including in Health and Social Care Partnerships. Specific arrangements will vary according to individual councils, but should be clearly articulated locally;

(b) to be able to bring matters to the attention of the Chief Executive to ensure that professional standards and values are maintained;

(c) to be visible and available to any social services worker and ensure the availability of robust professional advice and practice guidance;

(d) to provide professional advice as required to senior managers across the authority and its partners in support of strategic and corporate agendas.

26. Local authorities will need to agree:

(a) how the CSWO is enabled to inform and influence corporate issues, such as managing risk, setting budget priorities and public service reform;

(b) the specific access arrangements for the CSWO to the Chief Executive and elected members;

(c) the relationships, responsibilities and respective accountabilities of service managers and the CSWO;

(d) a mechanism to include an independent, professional perspective to the appointment of the CSWO;

(e) procedures for removal of a CSWO postholder, bearing in mind the need for continuity in the provision of the CSWO functions, the value of independent professional advice and the arrangements for the appointment and removal of the local authority's other proper officers;

(f) clear and formal deputising arrangements (with similar skills and experience available) to cover any period of absence by the CSWO and appropriate delegation arrangements where scale of business requires this.

27. This document complements the wide set of guidance underpinning the delivery of safe, accountable and effective social work practice and high quality social services in Scotland.

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at
The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

ISBN: 978-1-78652-358-7 (web only)

Published by The Scottish Government, July 2016

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS76000 (07/16)

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Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Agenda item : 5.10

Date of Meeting: **30 November 2016**

Title of Report: **Chief Officer Briefing**

Presented by: **Christina West**

The Integrated Joint Board is asked to :

Note the following report from the Chief Officer

Positive Report for Dementia Services within Mid Argyll Hospital

The Mental Welfare Commission (MWC) for Scotland recently carried out an unannounced inspection of Dementia Services within Knapdale Ward in Mid Argyll Hospital. They have now published their report and have made no recommendations or requirements.

During the visit the MWC looked at care and treatment plans and found them to be person centred and individualised with good evidence of regular evaluation. They also focused on the physical care and treatment of patients and found good links between the dementia ward and the medical ward.

The report also highlighted evidence of staff gathering information about individuals using the 'Getting to Know Me' booklets which allows anyone caring for that person to know more about them. These are personalised by staff caring for the person with photographs, drawings and personal information.

The report also highlighted that the ward environment was bright and clean with a quiet calm atmosphere and the MWC representatives also commented on the easily accessible garden area which can be entered through the ward.

Relocation of Inpatient Mental Health Services in Lochgilphead

Building and alteration works in Mid Argyll Hospital started on Monday 17th October to prepare the hospital for the relocation of inpatient mental health services from Argyll and Bute Hospital and it is anticipated the works will be completed by March 2017. The move to Mid Argyll Hospital will lead to much improved accommodation for patients and a facility that is more suitable for their needs.

The relocation is an interim measure pending further engagement with the public as to where the service will be provided in the longer term.

The HSCP will also be keeping local communities informed as the building works progress and a number of drop in events have been arranged for November and December. These events will provide the public with an opportunity to view the plans for the Mid Argyll Hospital unit and raise any questions they may have with HSCP representatives.

Top Awards go to Highland Healthcare Heroes

An individual and a team from Highland have scooped top awards at the Scottish Health Awards 2016 in recognition of their invaluable contribution to Scottish healthcare.

John Webb, First Responder and Heartstart trainer with Garelochead and Rosneath Peninsula Community First Responders, has won the Volunteer Award thanks to the commitment and kindness he has shown to his local community. John has attended many medical incidents for the Scottish Ambulance Service over the years, and has made a great difference to each of the patients he has helped.

The Audiology Team at Lorn and Islands Hospital took home the coveted Top Team Award. The team has been thoroughly praised throughout the UK for the unique practices and services they provide to children and adults. The implementation of new facilities and equipment unique to Scotland by the team has meant that all patients have been seen locally and looked after extremely well. The Audiology team has already secured its status as one of the very best in the UK.

Healthy Working Lives Award Programme

The Healthy Working Lives Award (HWL) Programme supports employers and employees to develop health promotion and safety themes in the workplace in a practical, logical way that's beneficial to all.

Across the HSCP there are 7 sites with a HWL award (5 gold, 1 silver and 1 bronze) and each year they have a annual review as part of the award process and all the sites have this year maintained their awards.

Cancers Support Coffee Morning

Mid Argyll Community Hospital and Integrated Care Centre recently held another successful coffee morning and raffle raising funds for Wear It Pink and Lochgilphead & District Branch of Macmillan Cancer Support. The sum of £2,562.88 was raised and split between the 2 charities. Thanks are extended to all those who supported the day by baking, donating raffle prizes or attending on the day.

This is the 10th anniversary of holding this event and it has always been popular with the local community. Over this period the generous people of Mid Argyll have donated £20,475.47 which is quite an achievement.

Reach Out – make a difference to someone who's lonely

Loneliness is a significant public health issue and more people die of being lonely than do from being overweight or inactive. It is on par health wise with smoking 15 cigarettes a day and contributes to diseases like dementia, heart disease and depression.

NHS Highland's Public Health Department developed a social marketing campaign to encourage people to talk about loneliness and reduce the stigma. This is called *Reach Out – make a difference to someone who's lonely*. The campaign launched in May this year and there has been ongoing promotion throughout Argyll and Bute.

The Community Planning Partnership signed up to the pledge at their annual conference in Oban on 2 November and IJB members are welcome to sign up to the pledge at *www.reachout.scot.nhs.uk*